The Hospitalist

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The Hospitalist:

Professional Boundaries, Professional Identity and Rationalized Myths

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Abstract Today's health care environment is increasingly confronted with continuity problems, as well as capacity problems. Hospitals have been experimenting with different solutions to solve these problems. Some of these solutions include the implementation of new medical professions to ensure vertical differentiation (to solve capacity problems) as well as horizontal integration (to solve continuity problems). As the researcher argues, it can be seen in both literature and practice that there is a need for more insight on what influences the success of implementation of such a function. Multiple authors have argued that whether a new function is able to reach its full potential depends on whether or not professional boundaries are shifted. This thesis analyzes the pilot education and implementation of a new medical profession, in four Dutch hospitals: 'the Hospitalist'. A case study with embedded units is performed. A Force Field Analysis is conducted to identify driving and restraining forces that influence the implementation of the Hospitalist. This thesis uses a multiple rationality approach for this analysis. Literature shows that both Professional Identity and Cognitive-Technical rationality could hold implications for the success of implementation. Multiple stakeholder groups were interviewed to build up an extensive view on the hospitals' readiness of implementation. Results show that both Professional Identity Rationality and Cognitive-Technical Rationality partly explain how stakeholders perceive the change initiative to implement the Hospitalist, and both rationalities provide for driving and restraining forces. It is also shown that some driving or restraining force could be originating from one's Professional Identity Rationality or one's Cognitive-Technical Rationality. In addition to this, the researcher argues that this multiple rationality approach leads to a more fruitful analysis of the readiness for change, whereas Cognitive-Technical rationality explains most of the readiness. Other factors that influence the success of information that were found in this research include (1) the disagreement on the Hospitalist's positioning and (2) whether the function is implemented in small-peripheral hospitals or large-academic hospitals. Recommendations, future research objectives and conclusions based on the findings above are discussed.

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1. Introduction

'…Lorraine Brewin, 46, underwent a routine operation on varicose veins in January 2009. However, she suffered a dangerous build-up of blood in her leg and was transferred to another hospital. Delays and a lack of physiotherapy meant her lower left leg had to be amputated 12 months later.' (Patrick Sawer, 2013)

Who has not experienced or heard about such hospital failures? Unfortunately, the story above is no exception. In 2009, research conducted by the Dutch Order of Medical Specialists showed that 1734 unnecessary deaths occur on a yearly basis (Start, 2009). These deaths are often the result of late diagnosis, poorly recorded patient files and wrong medication.

Today's health care environment is increasingly confronted with continuity problems, as well as capacity problems. Continuity problems arise from fragmented care, resulting from the fact that health care has become increasingly specialized over the years (Kathan-Selck and Van Offenbeek, 2010; Van Offenbeek, 2009). These continuity problems include poor coordination of care: most specialists are only concerned with the specific issue they are treating, and do not consider illnesses out of their relatively small specific field. As for capacity problems, there is a call for more patient-oriented health care, due to changes in populations, disease patterns, public and political expectations and new knowledge and technology (McKee et al, 2002). Especially in The Netherlands, where due to the ageing population more complex and chronic diseases are influencing the demand for health care in terms of quality, volume and variety. Throughout Europe, the same developments are noticeable; while health care demands are increasing, health care organizations are troubled with shortages of, among others, human resources, due to young physicians who want to work fewer hours (Lens, 2001; Buchan and O'May, 2002).

In order to solve the problems described above, hospitals have been experimenting with different solutions. One option that has shown positive results is the delegation of routine medical tasks to non-specialists (Scholten et al, 1999; van Offenbeek et al, 2002). The delegation of tasks is illustrated by the extended role nursing professions have taken on (Bowler and Mallik, 1998). Nurses have moved away from the 'traditional role' of being task-oriented (Paniagua, 1995), performing solely basic nursing skills (Thomas, 1993) and only as a response to doctor's orders (Dodds, 1991) towards the 'changing' role of working autonomously and patient-centered (Thomas, 1993). In addition to this, in the US, a medical role has been developed over the last decade: the Hospitalist. This profession has shown the potential to be an answer to some of today's challenges in hospitals. The Hospitalist increases horizontal integration and provides coordination for doctors and nursing professions, thus addressing the needs for more managed care and cost reduction through efficiency, while also increasing the quality of care (Wachter, 1996; 2006). In The Netherlands, hospitals have

also been experimenting with the introduction of a new medical occupation, the emergency physicians. Over the past few years, this profession has successfully developed into a group of doctors that reduce the coordination and quality problems present at emergency care in hospitals (Kathan-Selck & Van Offenbeek, 2010).

In an attempt to solve the continuity and capacity problems at hospitals' wards, and to improve patient-centered care, the Hospitalist profession, originating from the US, was introduced in a Dutch Hospital in the early 2000s (Jaspers et al. 1999). This profession was different from other physicians, since it was oriented towards a patient domain instead of a specialty (Van Offenbeek, 2004). The Hospitalist was meant to be a 'generalist', able to provide interdisciplinary care and coordination of care, and would be responsible for treating patients as well as managerial tasks. Since Hospitalists focused on routine, interdisciplinary patient care, they were meant to enhance vertical differentiation in the medical professions, as well as horizontal integration across specialties (Van Offenbeek, 2004). The vertical differentiation was expected to solve capacity problems by reducing specialists' and residents' workload, while the horizontal integration was expected to reduce problems in continuity of care by creating more stability through the fact that a patient had to see fewer doctors. (Van Offenbeek, 2004) However, even though its advantages were clear, the role of Hospitalist did not diffuse in the Netherlands.

Apparently, although demand for new medical professions to solve continuity and capacity problems is evident and recognized, difficulties and potential problems do exist. Various articles (Buchan and O'May, 2002; Kathan-Selck and Van Offenbeek, 2010; Van Offenbeek, 2004; 2009) have stressed the difficulties and potential problems of introducing new professions in multi-professional, highly-institutionalized organizations like hospitals. According to Kathan-Selck and Van Offenbeek (2010), introducing new medical professions requires the shifting of professional boundaries. The authors have identified forces influencing the shifting of professional boundaries in health care by using force field analysis, combined with risk areas in implementing innovations. It was found that when introducing a new medical profession, boundary shifting could occur in three domains: Authority-, Patient-, and Knowledge-Domain. This implies that new occupations question existing professions' domains. According to Kathan-Selck and Van Offenbeek (2010), this raises certain questions: '*Should non-specialists be allowed to autonomously see patients in a secondary care setting? Is it acceptable that a multidisciplinary physician provides care to patients who were formerly "owned" by a specialty?*' These questions, as well as the effect that shifting professional boundaries has on an organization and individuals, could be viewed differently by various professionals within a hospital.

Over the past years, a new pilot has been developed in the Netherlands to retry the implementation of the Hospitalist, again based on the developments in the US. The main difference compared to the initial attempt in 2003 is that this time, the Hospitalist is not bound to one specialist. This time, the pilot is an attempt to

create a whole new group of physicians, whereas the initial plan entailed a physician to be educated by and stay working for a single specialty department in the hospital. In addition to this, the recent is conducted in more hospitals. This new profession is meant to further improve healthcare and reduce the increasing complexity, continuity and capacity problems. As literature stresses (Offenbeek, 2004; Kathan-Selck & Van Offenbeek, 2010; Buchan and O'May, 2002), possible consequences of this new medical profession must be monitored and evaluated if the project is to be successful. This paper seeks to discover and create understanding about what forces influence the readiness for change when introducing new medical professions.

In this thesis, the view of relevant stakeholders on the shifting of professional boundaries and the overlap in tasks and authority that may be created by implementing new professions is analyzed. This will be done to assess whether hospitals in the Netherlands are likely to incorporate the new medical profession, considering stakeholders' view on the shifting of professional boundaries. Force Field Analysis (FFA) has proven to be an effective method for assessing the readiness for change in an organization (Lewin, 1951; Cawsey et al., 2012), also in the context of health care (Bozak, 2003; Baulcomb, 2003). FFA is an analytical model, which means that it provides a tool for assessing a certain situation, in this case: the organization's readiness for change. An analytical model as FFA does not provide a theoretical lens through which a certain phenomenon is viewed. However, it does provide the basis of analysis, which can be combined with organizational theories. The accuracy and relevance of a FFA depend on the theoretical lenses that are used to make the FFA. This thesis will combine two theories within the FFA.

Weber (1978) argued that when analyzing behavior or organizational change, rationality should not be viewed as one-dimensional. Rather, it is the combination of different dimensions of rationality that form the rationalized myth of how one assesses a certain change initiative (DiMaggio and Powell, 1983). It is argued by several authors (DiMaggio and Powell, 1983; Townley, 2002) that the rationalized myth of a stakeholder should be unraveled into parts of rationality to be fully understood. This implies that some parts of one's rationality could foster acceptance, while other parts thrive resistance (Townley, 2002). In addition to this, March et al. (2004) have explained this phenomenon further on the individual level with Appropriateness theory. The authors state that behavior cannot just be explained as rule-following. Rather, it is the result of combining roles, identities, rules, situations and institutions.

Various authors (Weber, 1987; Brubaker, 1984) have identified multiple types of rationality. This thesis takes into account two types of rationality that are relevant lenses to look at professional boundary shifting and overlap: professional identity rationality and cognitive-technical rationality. These two perspectives are relevant for boundary shifting and overlap, since theoretically, both offer arguments driving and restraining the shifting of boundaries. On the one hand, based on cognitive-technical rationality, it can be argued that overlap in tasks

leads to more flexibility in an organization (Landau, 1969). On the other hand, professional identity rationality claims that professions will aggressively defend the boundaries of their occupation (Kenny et al. 2011).

The existence of these rationalities is illustrated by Mossé et al. (2010). The author investigates the trend in France that hospitals are using wide a wide variety of strategies to become increasingly flexible (as a reaction to environmental pressures: higher competitiveness and fluctuations of demand). At first sight, this can be seen as a cognitive-technical reason for change. However, it was found that the demands for this flexibility was seen differently depending on one's professional background.

Although the identification and evaluation of 'forces' driving and restraining change has been done before in the multi-professional, institutionalized healthcare context (Kathan-Selck and Van Offenbeek, 2012), none have looked at professional boundary shifting and overlap through the combination of theoretical lenses that this article does. The literature discussed above suggests that considering multiple dimensions of rationality may provide for deeper insights in driving and restraining forces for professional boundary change; one's perception of a change does not just depend on the cognitive-technical rationality, nor does it depend solely on professional identity rationality: it is the combination of the two dimensions of rationality that form a rationalized myth. Or as Townley (2002, page 165) explains it:

'The value of identifying these different types of rationalities is that they are not antithetical, thereby forcing an either/or analysis. Rather, all are operational (…) Dimensions of rationality combine or struggle against one another in a tapestry of shifting balances. They may coalesce and conflict. This shifting allows for a dynamic analysis of responses to rationalized myths [change initiatives] in which one can trace elements of accommodation and resistance (…) and for the identification of internal tensions and contradictions.'

Based on the problems and theoretical concepts stated above, this thesis' research question is:

> Which driving and restraining forces for implementing a new medical profession in a multi-professional and institutionalized environment can be identified by taking a multi-rationality approach, combining stakeholders' cognitive-technical rationalization and professional identity rationalization of professional boundary shifting and overlapping domains (in knowledge-, patient- or authority- or other domains)?

Elaboration and sub-question are formed after extensively discussing literature and background in the next section. This paper seeks to combine the practical need to explore the readiness for the implementation of new

medical professions to improve capacity and continuity on hospital wards, with the theoretical need for a deeper understanding of forces that influence institutional change seems. A hospital's context is highly complex, multi-professional and institutionalized, thus provides for multiple perceptions on change initiatives: not only will there be differences in results of the change among medical occupations, but also identities of the professions differ. This context seems ideal to analyze with the combined rationality approach described above.

The fact that the shifting of professional boundaries and overlap is one of the major issues in implementing new medical professions makes this study relevant for practice. Exploring in depth what perceptions different stakeholders have on such a change will provide for more understanding of the issues that come in to play when implementing new medical professions. Furthermore, looking at driving and restraining forces through the lens of multiple rationalities might also provide for more accurate remedies: How can a restraining force be reduced if the rationale of this specific force is not found and addressed? The theoretical relevance also lies in the in-depth analysis of forces. The analysis may identify issues that could be subjected to further research. In addition to this, this paper addresses and shows the effects of stepping away from the one-dimensional view of forces that influence change, towards a view of multi-rationality, which may provide deeper insight in the dynamic of institutional change.

This paper continues by elaborating on the theoretical concepts introduced above in the second section. This section will be concluded by stating the main research question and sub-questions. In the third section, the methods used for answering the research question as well as acquiring and analyzing data are discussed. Fourthly, the findings are described, illustrated by quotes from interviews and summarized. The final section of this thesis discusses the findings, explains their relevance and reflects on implications of this study, discusses its limitations and suggests future research paths.

2. Literature

The Literature Section elaborates on the theories and concepts introduced in section one. Firstly, hospitals' context is discussed to provide insights into the specific field of research. Secondly, the emergence of the Hospitalist is discussed, explaining this medical job's relevance. Thirdly, this section explains what shifting professional boundaries and overlapping domains entail. Fourthly, this section discusses the concepts used in the research: Rationality theory, professional identity rationality, cognitive-technical rationality and Force Field Analysis. Conclusions will then be drawn based on the literature review. Finally, the main research question and sub-questions will be stated and elaborated on at the end of this section.

2.1 Context

Before discussing the literature used in this research, it is important to have some insights into the context of a hospital, since it is vital for understanding how the dynamic of a hospital ward is influenced by implementing a new medical profession. Multiple authors (Buchan & O'May, 2002; Kathan-Selck & Van Offenbeek, 2010; McKee, 2002) describe the context of a hospital as institutionalized, multi-professional, complex and changing rapidly. Task structures in hospitals can be described as complex, and hospitals have a diffuse internal division of labour. As is also illustrated in the introduction of this thesis, changing populations, continuity and capacity problems, increasing demand and cost pressures have urged hospitals to rethink their processes and actively search for initiatives to improve health care, as well as reducing costs.

Since Kathan-Selck and Van Offenbeek (2010) have stressed in their research that for new medical professions to reach their full potential, professional boundaries must be shifted, the fact that hospitals are highly institutionalized and multi-professional becomes important: this entails that more people will be affected by implementing new professions. Professional boundary shifting also entails that certain occupations' job description will change, which could result in parties opposing the initiative.

Considering the above, it is important to introduce the Physician Assistant (PA) and the Nurse Practitioner (NP): two nursing professions working on a hospital wards. Both occupations perform medical procedures previously done by doctors (Zwijnenberg & Bours, 2011). It is argued that both NPs and PAs serve as a substitute for doctors (by performing basic medical treatment), but also as a supplement (by performing new tasks which was no capacity for earlier). The specific tasks that NPs and PAs perform include direct patient care like medical activities, nursing activities, diagnosis, treatment of patients, prescribing medication and admitting/discharging patients. In addition to this, both PAs and NPs also engage in indirect patient care like communication, ordering laboratory tests, consultation requesting, making rounds, administration and evaluation of care (Zwijnenberg & Bours, 2011). It is stated that both professions were introduced to enhance

continuity and coordination. Since these were also reasons for developing the Hospitalist, it seems logical that some of the Hospitalist's domain will overlap with the domains of PAs, NPs or both. For the Hospitalist to reach its full potential, the boundaries of the overlapping domains must be shifted. This thesis investigates which forces influence the shifting of professional boundaries.

2.2 The Emergence of the Hospitalist

The role of the Hospitalist has not only been explored in the Netherlands. In the US, the early development of this medical job was the result of the explosive growth of managed care (a variety of techniques to reduce costs and increase quality of care), the rising demand for generalists and the need for efficient care due to the increased cost pressures (Wachter, 1996). This role was not, like in The Netherlands, performed by a whole new medical profession, but as an extended role for general internists and primary care physicians (Wachter, 1996). Occupational role extension can be defined as taking on tasks that are outside of the original job description and that were not trained in the occupation's preregistration phase (Wright, 1991).

In the US, the main goals also included continuity of care and comprehensiveness, with the intended effect being 'holistic medical care'. Wachter (1996) describes the Hospitalist as follows:

'As a result, we anticipate the rapid growth of a new breed of physicians we call "hospitalists" —specialists in inpatient medicine — who will be responsible for managing the care of hospitalized patients
in the same way that primary care physicians are responsible for managing the care of outpatients.' – Wachter (1996)

Wachter (1996) describes the Hospitalist movement as a reaction towards the diminishing value of the 'triple threat' leader – a skilled clinician, researcher and educator, since health centers have become increasingly accountable for the quality and cost of medical care. One of the advantages of Hospitalists, according to the author, is that the movement creates a core group in the hospital that is committed to quality improvement. This is also argued by Cors et al. (2010). The authors identified that the decreasing physician participation in hospital affairs is one of the driving forces for hospitals to start a Hospitalist program. The authors also identified deteriorating clinical revenues and the increasing complexity of hospital practice as reasons for employing hospitalists.

It was recognized that the Hospitalist would be an attending physician capable of providing supervision to house staff, like nursing professions, since the Hospitalist would be more skilled and experienced in providing inpatient care. This supervision might be a cause for negative reactions at transition, since autonomy and authority of nursing professions would be diminished. In addition to the diminishing autonomy and authority, primary care physicians were worried that the Hospitalist would block their access to inpatient medicine, due to

their role extension. However, promoting flexibility in implementing the Hospitalist model reduced primary care physicians' worries: Hospitalists would not necessarily block primary care physicians access to inpatient care, that depended on how a hospital ward was organized locally. It was promoted that Hospitalists would provide better coordination, not that other professions would become obsolete. The fact that specialists feared that skilled Hospitalists need fewer consultations, had proven the most difficult fear to address. If it would be the case that specialists were consulted less often, their income would decrease. This fear amongst specialists was identified as the root cause for the Hospitalist model failing in some cases (Wachter, 2006).

Although initially Hospitalists in the US were subspecialists, focusing on hospital medicine for only part of their work, the field later evolved into generalists, like now in the Netherlands (Wachter, 2006). The exact reason for this evolution is not clearly researched, although it is speculated that the extended role became so large and time consuming over time, that Hospitalists abandoned their initial role (most of the time the role of Internist). Based on this, one could argue that although the Hospitalist role started out as role extension for other professions, the development later evolved in a matter of role transition: the movement of individuals out of one role and into another (Turner, 1990).

Although the number of Hospitalists in both academic and non-academic hospitals were growing enormously, some problems did emerge. These mostly included the negative attitude towards what was described by opposing stakeholders as '*physicians thinking like MBA's*' and '*forgetting the most important part of medicine: the relationship between the doctor and patient*' (Wachter, 2006, page 249). It was argued that doctors were forgetting the most important part of being a physician: curing patients, and were focusing more on the hospital's efficiency and cost reduction. Wallace and Schneller (2008) argued that problems emerged because of political reasons. The authors draw on Abbott's famous work that analysis should consider professions to be a system, all professions influencing each other. It is argued that implementing the Hospitalist is difficult, because change has implications for all professions in a hospital. The authors describe how, even though interests were divergent amongst powerful stakeholder groups, acceptance of the new medical profession was fostered. First of all, their results show that a common rationale must be found between stakeholders. In this case, this was 'reducing costs and increasing patient safety'. This rationale should then be emphasized on by the initiators, and later by an organization or 'movement', during campaigns and discussions. Finding strong support from other professions, like internists, also proved to foster acceptance among other stakeholders. In addition to this, experience gained in local initiatives should be communicated to other local initiators. Secondly, the authors recognized that acceptance was fostered by culture-building and communication among stakeholders. In some successful cases of implementation, physicians were invited to work as Hospitalist for a while, and help create the best solution as well as pursue their own interests. Finally, Wallace and Schneller (2008) argued that senior medical management at the local and national level were able

to promote the new profession without resorting to more formal processes of creating official specialties or rigidly accepted roles. The authors call this 'orchestration', which is presented as a major strategy for guiding emergent change to ensure role flexibility. However, the authors also argue that legitimizing local hospitalist activities is necessary to foster wide acceptance. Wachter (2006) argued that attitudes shifted in the US because it was explained that the hospitalist movement was based on measuring clinical outcomes, costs and satisfaction rather than by following passion or tradition; this would improve the quality of healthcare rather than harm it. In addition to this, empirical data showed that hospitals were more and more employing Hospitalists and with positive results (Wachter, 2006). Frank et al. (2011) reported results from a pilot hospitalist program in the US. The results show that within six months, the pilot hospital had achieved a $2204 per discharge in savings, and overall patient and physician satisfaction had increased. In addition to this, Harrison and Curran (2009) found a positive correlation between hospitals employing a hospitalist model and reduced length of stay in hospitals and enhanced quality of health care.

The evolution of the Hospitalist in the UK in the early 1990s, as described by Wachter (1996), gave birth to early experimenting with that function in the Netherlands (Jaspers et al., 1999). This attempt is described by Van Offenbeek (2004). Although the benefits of this function seemed clear to all the stakeholders, the role did not diffuse. Now, hospitals in The Netherlands are conducting a renewed attempt educating Hospitalists and facilitating their implementation.

An important note when comparing the two developments (in the US and in the Netherlands) is that although the Dutch Hospitalist is based on the role in the US, the fact that in the Netherlands a whole new educational program will be created. Also, the Hospitalist will be a totally new medical profession in the Netherlands, which differs significantly from the situation in the US. This difference in approach indicates the following points of interest. 1) Hospitalists in the US have been Internists before, and have either taken on extended roles or have transitioned into new roles. This entails that US Hospitalists are experienced doctors, whereas in The Netherlands Hospitalist are doctors coming right out of school. 2) Although in the US the role started out as an extension to the traditional role of Internist, this development changed into role transition. Based on this change from role extension towards role transistion, one might argue that hospitals in The Netherlands are making the right choice by designing a whole new medical profession, instead of extending other roles. Apparently, based on the experience in the US, the Hospitalist role is too large and time-consuming to take on as a part of one's work.

Despite these two differences, it is interesting to look which driving and restraining forces can be identified from the experiences in the US, since this indicates what to look for when analyzing the Dutch development of the Hospitalist. *Figure 1* summarizes the identified forces, with driving forces on the left and restraining forces on the right. All of these forces seem relevant for the Dutch implementation of the

Hospitalist, since they do not differ whether the Hospitalist role is an extended role, or a whole new medical profession.

Driving and Restraining Forces

Driving Forces	Restraining Forces
Promoting flexibility of implementation resulted in a reduction of opposition (Wachter, 2006; Wallace & Schneller, 2008)	Nursing professions' fear of loosing their access to inpatient care might result in resistance (Wachter, 1996).
The Hospitalist movement was based on measuring clinical outcomes and measuring costs, satisfaction and the time a patient spent in the hospital (Wachter, 2006; Frank, 2011; Harrison & Curran, 2009).	Concerns about physicians focusing to much on effeciency and cost reduction (Wachter, 2006).
Finding a common rationale between stakeholders, sharing experience, public speeches and discussions fostered acceptance (Wallace & Schneller, 2008).	Specialists' fear of reduced income, because of the lower need for consultations, resulted in resistance (Wachter, 2006; Wallace & Schneller, 2008)
Getting the support of powerful stakeholder groups proved to be helpful in convincing other opposing stakeholders (Wallace & Schneller, 2008).	Divergent interests among powerful stakeholders makes designing and implementing the Hospitalist Model more difficult (Wallace & Schneller, 2008)
Engaging other physicians in the design phase of the Hospitalist Model proved to foster acceptance (Wallace & Schneller, 2008)	

Figure 1: Forces based on US experiences

2.3 Shifting Professional Boundaries and Overlapping Domains

Before discussing the theory used in this thesis, this subsection first addresses which professional domains might be affected by the implementation of the Hospitalist; where could professional boundary shifting occur? In their research on the implementation of the Emergency Physician (EP), Kathan-Selck and Van Offenbeek (2009) identified three domain types, whose boundaries could be shifted. These are the following:

(1) *Authority domain*

The Hospitalist's job description clearly entails the role of organizational coordinator. This shifts existing boundaries within the authority domain: specialists' traditionally unrestricted authority will be affected, as was also true in the EP case (Kathan-Selck and Van Offenbeek, 2009).

(2) *Patient domain*

Like in the EP case, Hospitalists will take over the responsibility for patients from other professionals. This clearly affects specialists, since they were originally the ones responsible for patients. In addition to this, Hospitalists will most likely take over routine patients from nursing professions, these patient streams were previously served by physician assistants or nurse practitioners.

(3) *Knowledge domain*

Hospitalists will require less supervision than the professions performing routine tasks in the existing context, since Hospitalists will have wider and deeper knowledge than the nursing professions. This will definitely affect the role of these professions, and will also require specialists to delegate knowledge to a doctor outside their specialty.

Kathan-Selck and Van Offenbeek (2009) argue that for a new medical profession that entails horizontal integration, like the Hospitalist, professional boundaries must be shifted if the profession is to reach its full potential. The authors found that in some cases EPs were assimilated into existing structured rather than professional boundaries being shifted, hence the expected of the new medical profession value was not achieved.

2.4 Rationality and Appropriateness

In his work, Weber (1978) emphasized that analyzing behavior, action and organizational change should be done by analyzing dimensions of rationality, instead of rationality as a whole. When combined, these dimensions of rationality form a rationalized myth (DiMaggio and Powell, 1983) i.e., how one sees the world, or in this case, a certain change. Many authors (DiMaggio and Powell, 1983; Meyer and Rowan, 1977) have researched the effect of the rationalized myth on organizations and the way myths become incorporated into organizations.

In relation to organizational change, this means that identifying different dimensions of rationality can be used to explain which parts of a rationalized myth fosters acceptance and which parts result in resistance (Townley, 2002). In other words: which part of one's rationalized view on a certain change promotes the change (driving forces) and which part inhibits the change (restraining forces). Considering different dimensions of rationality will enable us to analyze change forces more closely, because it allows us to match the driving/restraining forces with their respective dimensions of rationality, and investigate which theory explains the force's origin. Not only will this help explain the readiness for change in specific situations better, it could

also prove to be useful for management. Realizing where driving/restraining forces originate from is crucial for finding an appropriate remedy.

This is illustrated by Townley (2002). She examined to what extent the nature of the rationalized myth facilitates its acceptance or resistance. It was found that ambivalence in responses to the change, introducing a strategic performance measurement system in a provincial government division, could be explained by competing legitimacies, that is: competing dimensions of rationality. As Townley (2002, p. 176) explains it:

'Identifying dimensions of rationality disentangles the elements of rationalized myths, showing that they are not one-dimensional, but operate on several levels. These different levels prompt a range of responses in organizational actors.'

The concept of competing dimensions of rationality is also noticeable on the individual level. March and Olsen (2004; 1994) explain that actors in an organization take reasoned action by answering three questions: '*What kind of a situation is this? What kind of a person am I? What does a person such as I do in a situation such as this* (P. 04)?' The authors claim that certain behavior cannot be predicted as just following certain appropriate rules. Rather, the combination of rules and identities explains that predicting behavior comes from knowledge about roles, identities, rules, situations and institutions. Furthermore, March and Olsen (2004) describe that there is a potential tension between the identity-based logic of appropriateness and the preference-based consequential logic: what is appropriate based on the outcome of a certain action, is not necessarily appropriate based on one's identity. The authors illustrate this by explaining that a politician might get 'dirty hands' from time to time: '*Achieving desirable outcomes through methods that they recognize as inappropriate'* – March and Olsen (2004, P. 18).

In short, March and Olsen's (2004) argument strengthens Townley's (2002) claim that rationality should be analyzed through its different dimensions, just as appropriateness should be analyzed through its different components when describing or predicting behavior and organizational change. The next part of this subsection explains how rationality and appropriateness is used in this thesis, and which dimensions of rationality are used.

Weber (1978) addresses four types of rationality in his work, namely: practical, theoretical, substantive and formal. However, it can be argued that there are more types. Multiple authors (Swidler, 1973; Kalberg, 1980; Brubaker, 1984) have addressed Weber's view on rationality, although giving a clear definition is close to impossible. Brubaker (1984), for example, identified 16 meanings of the word 'rational'.

It is crucial to address the rationalized myth (how one sees the change initiative) with dimensions of rationality that are most important for the specific subject. In this case: Professional identity rationality and

cognitive-technical rationality are initially selected as the dimensions of rationality that, according to the existing literature seem to be most important for how one evaluates the shifting of professional boundaries and overlap. So, professional identity rationality and cognitive-technical rationality are selected as theoretical lenses in this analysis. The relevance of rationalization theory is not in finding predetermined types of rationality, but the knowledge that people rationalize action and opinions multi-dimensionally.

The next subsection discusses the dimensions of rationality that were selected, namely Professional Identity Rationality and Cognitive-Technical Rationality, and argues why that specific theoretical lens is relevant when evaluating the readiness for shifting professional boundaries.

2.4.1 Professional Identity Rationality

Abbott (1988, p. 7) defines a profession as '*and occupational group with some special skill.*' The author looks at professions through their jurisdictions, the tasks they do, and the expert knowledge needed for those tasks. Abbott (1988) also discusses how competitive forces change both jurisdictions and tasks. He analyzes the relationships between professions cooperatively and competitively. It was argued that change in the professional structures could happen in two ways. Firstly, through objective problems: professional tasks are threatened through problems arising naturally, or through technological developments. Secondly, through subjective problems, as Abbott explains it: '*activities of other professions impinging on the subjective qualities*' (Abbott 1988, 39). Objective problems arise through forces out of the context of occupational groups, whereas subjective problems arise from internal forces: competition amongst occupational groups. The author believes that the power of professions lay in their jurisdictional power. This jurisdictional power sets the boundaries of an occupation's work. It is showed that professions struggle and compete against each other for control over areas of task and jurisdiction (Abbott, 1988). The subjective nature of tasks is described as the cultural logic of professional practice.

Kenny (2011) also argues that a strong shared sense of norms and values, in other words a culture, is not only noticeable as a property of nations and organizations; occupations are also subject to this phenomenon. This implies that an occupational culture has a strong influence on how people see themselves. This entails defining yourself (who I am), but also defining others in terms of professional identity (who I am not) (Kenny et al, 2011). In many occupational fields, the fact that others might enter one's professional domain is perceived as a threat for three reasons:

(1) Others might be seen as less-skilled due to a lower social status, thus the risk of underperforming on certain tasks might lower the status of the whole occupation.

(2) The lower status might have material consequences: reducing the level of skill necessary to perform a certain task may lead to lower remuneration of that specific task (Kenny et al, 2011).
(3) Competition for work. More professionals compete for the same work, and ultimately job (Abbott, 1988).

Given the three reasons above, professionals are hesitating to delegate certain occupational tasks to others. In the case of the Hospitalist: specialists might want to protect certain elements of their professional identity, while the hospitalist's job description might dictate them to take over certain jobs previously performed by specialists, nurses, or physical assistants. Aggressively defending the boundaries of one's professional identity by specialists, specialized nursing professions, residents, or physician assistants is a phenomenon known as 'turf-wars' (Kenny et al., 2011; Abbott 1988).

As evidence for the relevance of considering professional identity when implementing new medical professions, Mueller et al. (2004) found that specialists experienced role changes occurring in hospitals as threatening. They felt that professionals with management tasks, like the Hospitalist, undermined their professional identity as autonomous professionals who could decide what was best for their patients.

2.4.2 Cognitive-Technical Rationality

Landau (1969) discusses the rationality of overlap from a functional (cognitive-technical) point of view. The author claims that overlap can, paradoxically, lead to redundancy and duplication of tasks, as well as to reliability and flexibility within an organization. To illustrate this, think of a certain task in a production company, like measuring whether a machine is operating to its full capacity. If there are two employees in this organization who both have the capabilities, knowledge and authority to perform this task, there can be two effects: 1) When one of the employees is ill, or busy with other tasks, the second fulfills the required task (Reliability and Flexibility); 2) Both employees check the machine's numbers, so one of them wastes time (Redundancy and Duplication).

The fact that cognitive-technical rationality of boundary shifting and overlap is relevant the context of implementing new medical professions in healthcare organizations, is illustrated by Van Offenbeek et al. (2009). Research was conducted on the implementation of another new medical occupation and overlap that occurred: the Nurse Practitioner. This research found that structural flexibility of the hospital was increased because of the overlap in tasks that was created.

As can be seen in the literature described above, the two dimensions of rationality that this thesis proposes to exist when assessing professional boundary shifting and overlap have certain effects on how one evaluates a certain change initiative and, therefore, on one's readiness for change. More specifically: Cawsey et al. (2012)

describe that support of change is a combination of two variables: 'perceived impact of the change on the organization' and 'perceived impact of the change on the individual'. The authors claim that if the change has a positive impact on both the organization and the individual, support will be the strongest. In addition, the authors claim that the effects on the individual influence one's support of the change the most: if the impact on the individual is positive, people are most likely to support the change, even when consequences for the organization are negative. Based on this, it could be expected that cognitive-technical rationality has a lower weight in the rationalized myth than professional identity rationality.

2.5 Force Field Analysis (FFA)

According to Lewin (1951), organizational change involves a struggle between forces that either push the organization towards maintaining the status quo, or forces that push intended change forward. The implication behind this is that the different forces regarding the intended change should be identified and evaluated. FFA is seen as a useful tool to assess these forces before implementing a change. After this, the perceived forces should be evaluated on whether or not they can be easily modified: Which inhibiting forces can be reduced and which pushing forces can be strengthened, with the least effort (Salaheldin, 2003)? At best, a FFA provides managers with useful information to formulate an appropriate strategy for the implementation of the change, and provides researches with important concepts to focus on in further research.

Lewin (1951), being a social psychologist, placed the FFA in the field of psychology: forces are identified through the psychological activity that confronts an individual when assessing a certain change. Several authors (Huse, 1982; Harvey and Brown, 1992) have also stated that when assessing pushing and inhibiting forces caused by people in an organization, these forces should be perceived by the relevant stakeholders. These forces could be recognized by top-management, but will not influence the status quo on the lower level of the organization if stakeholders on that level do not perceive those forces. So, observing and interviewing stakeholders is always a necessity for making a relevant FFA.

Several studies that made use of FFA have been conducted in a healthcare context. Bozak (2003) followed the implementation of a Nursing Information System, where hospitals moved from bar code technology for medication administration to wireless bedside documentation systems to clinical decision support systems. The author found, through FFA, that (1) the proposed change must be viewed as a challenge rather than a threat, (2) a well-formulated strategy encourages adoption of change rather than resistance, (3) setting project goals, careful planning, good communication, involvement of those affected by the change and support of management are crucial components for successful implementation. The author concluded that FFA provided the necessary framework for guiding the change, because it clearly visualizes the situation the organization is in, analyzes the barriers for change and the change's drivers, and helps defining strategies on how to strengthen the drivers and eliminate or reduce the barriers.

Baulcomb (2003) has stressed the importance of reflecting on potential benefits (for patients, staff and the organization as a whole) of changes in the rapidly changing context of the healthcare environment. The author reflects on the fact that traditional nursing roles have an ever-increasing management responsibility, using FFA. He studies the proposal for a change of shift system in a hematology/oncology day unit in a UK hospital, that was intended to promote better utilization of nursing skills and management experience. It was found that the FFA model sufficiently explained driving and restraining forces and their implications.

Based on the articles mentioned above, FFA seems useful for assessing the readiness for change. In this case, the implementation of the Hospitalist, that is the readiness or likelihood that professional boundaries are shifted. This is necessary for the new medical profession to reach its full potential. FFA is also considered a suitable way of addressing different stakeholders' view on a certain change initiative (Cawsey et al., 2012), which is exactly what this thesis aims to do. In fact, stakeholder analysis (SHA) and FA contribute to each other: SHA is a necessity for considering what stakeholders to address when assessing the readiness for change. The FFA is drawn by using the steps described by Senior and Swailes (2010).[1]

2.6 Conclusion

Theory suggests that professional identity rationality stresses potential dangers (occupations defending their professional boundaries aggressively), whereas cognitive-technical rationality proposes mostly benefits (structural flexibility). However, it is possible that both rationalities have opposite effects as well; Identity rationality that drives change and cognitive-technical rationality that inhibits change. This possibility will be explored in this research, as can be seen in *Figure 1.* This figure will be used to report the results later in this thesis. The results will also be combined into a Force Field Analysis, which, according to literature, has proven to be an effective analytical model to assess a certain situation.

Rationalities influencing Boundary Shifting and Overlap

	Cognitive-Technical Rationality	Professional Identity Rationality

[1] Force Field Analysis Steps by Senior and Swailes (2010, page 270)
Step 1: Define the problem in terms of present situation and define the target situation.
Step 2: List the forces working for and against the changes.
Step 3: Rate each force for and against change in terms of strength: high, medium or low.
Step 4: Using a diagram, draw lines of different lengths to indicate the different strengths of the forces.
Step 5: Label each line to indicate whether that force is very important, important or not important.
Step 6: For each important force supporting change, indicate how the force might be strengthened. Do the same for forces opposing change, but in this case indicate how they could be weakened.

Driving Forces	For instance:Increase in structural flexibility (Offenbeek et al., 2009), others researched during case study.	To be explored during case study
Restraining Forces	To be explored during case study	For instance: 'Turf Wars', others explored during case study.

Figure 2: Driving and Restraining Forces based on Cognitive-Technical and Professional Identity Rationality

2.7 Research question

This subsection states the main research question and sub-questions. Based on the theoretical concepts explained in the previous sections and the aim of this thesis to evaluate the readiness for shifting professional boundaries considering different stakeholders, the following research question is stated:

> Which driving and restraining forces for implementing a new medical profession in a multi-professional and institutionalized environment can be identified by taking a multi-rationality approach, combining stakeholders' cognitive-technical rationalization and professional identity rationalization of professional boundary shifting and overlapping domains (in knowledge-, patient- or authority- or other domains)?

To successfully answer the question stated above, the following **sub-questions** must be answered:

(1) *What cognitive-technical rationalities of stakeholders on boundary shifting and overlapping domains can be identified as (a) driving forces and (b) restraining forces?*

(2) *What professional-identity rationalities of stakeholders on boundary shifting and overlap can be identified as (a) driving forces and (b) restraining forces?*

(3) *Are the identified forces mentioned above a result of overlap in knowledge-, patient-, or authority-domain, or can other domains or causes be identified?*

The research question and sub-questions will be used to draw up an elaborate Force Field Analysis (FFA). FFA is an analytical model, which is well suitable for combining it with organizational theories. In this case, the FFA will be used to incorporate both dimensions of rationality discussed in the section above: cognitive-technical rationality and professional identity rationality.

This thesis continues in the next section with addressing the case of implementing the Hospitalist in The Netherlands that was studied and explaining the methods that were used to answer the main question and sub-questions.

3. Methods

After having described this thesis' theoretical concepts and research goals in previous sections, this section discusses the methods used in this study. Firstly, the case context is described. Secondly, the research design is explained. Thirdly, it is argued which data collection methods have been used. Fourthly, the coding strategy that was used is explained. Finally, data analysis is explained before continuing to the results.

3.1 Case Description

This thesis analyzed the pilot education and implementation of a new medical profession, in the Netherlands: 'the Hospitalist'. This pilot started in 2012, when the first Hospitalist started their education and started working in Dutch hospitals. The purpose of this medical profession is to meet the rising demand for generalist doctors in the hospital setting, and will fulfill an integrative role in the current spectrum of medical professions. Also, the Hospitalist will have the capacity to deliver 'healthcare based on demand', rather than in a supply driven manner (Oosterhuis and Van Offenbeek, 2003). In addition, this profession is meant to reduce the fragmentation of medical diagnoses and treatment processes, thus improving continuity in hospitals.

3.2 Case Sampling

The pilot takes place in four Dutch hospitals, UMCG Groningen, Jeroen Bosch Hospital 's Hertogenbosch, Catharina Hospital Eindhoven and VU Medical Centre Amsterdam, and will run for three years. The pilot's goal is to develop a high-quality educational curriculum for Hospitalists, as well as testing the functionality of this profession in practice.

This suits the purpose of this research well, since the hospitalist will be a non-specialist, cross-disciplinary profession in a health care organization. The profession entails vertical differentiation and horizontal integration. This makes it likely that professional boundaries are shifted and overlap is created (Van Offenbeek et al. 2009, Kathan-Selck & Van Offenbeek, 2010).

For the purpose of successful implementation, it is important to address stakeholders expectations in order to identify sources that will inhibit the change (Restraining Forces), as well as sources that will push change forward (Driving Forces). The fact that the pilot project has just started, provides for a great time to look at stakeholders' rationalization of the change initiative, and thus assessing the readiness for change.

This thesis assumed the education and implementation of the Hospitalist in the Netherlands as one case, not as four separate cases in four Dutch Hospitals. This was decided for two reasons: 1) The low number of stakeholders that could be interviewed made it impossible to compare the four on all dimensions, 2) Some stakeholders interviewed could not be placed within the context of one specific hospital. However, if important differences in trends were recognized among the hospitals, these are reported and explained in the results. This

design can be seen as a single case with embedded units (Baxter and Jack, 2008). This design provides the opportunity to look at differences between sub-units when analyzing a larger case.

As is usual in theory development, this case was selected for theoretical, not statistical reasons (Eisenhardt, 1989). This case was selected because it provides for the extension of existing theory. Previous research on boundary shifting and overlapping domains has also considered the institutionalized and multi-professional healthcare context (Kathan-Selck and Van Offenbeek, 2010), and this context has proven to a fruitful source for research in this theoretical field. This is because the hospitalist will be a non-specialist, cross-disciplinary profession in a health care organization, it is likely that professional boundaries are shifted and overlap is created (Van Offenbeek et al. 2009, Kathan-Selck & Van Offenbeek, 2010).

Although this case is considered as one, not four separate cases, there are certain differences between the hospitals in this case (sub-units). It can be seen from literature that, compared to non-academic hospitals, academic hospitals are relatively more acceptant to change, because of the academic initiatives and research (Theokary and Ren, 2011). In addition to this, an academic hospital's context is different from a non-academic one, mostly because of the lower number of different professions (Lindors et al., 2008) It is also argued that capacity and continuity issues are more present in small non-academic hospitals, since in an academic setting, the large number of various doctors solves some of the problems (Gellis, (2001). Based on these differences, two groups can be identified in this case, each consisting of 2 sub-units for a total of 4 sub-units (size is based on the available number of beds for patients): 1) small-peripheral hospitals and 2) large-academic hospitals. If differences are noticed, they will be discussed in the results section.

3.3 Data collection methods

This sub-section discusses the data collection methods and explains how stakeholders were selected for interviews. Data for the first two questions was collected simultaneously.

1. *What cognitive-technical rationalities of stakeholders on boundary shifting and overlap can be identified as a)driving forces and b) restraining forces?*
2. *What professional-identity rationalities of stakeholders on boundary shifting and overlap can be identified as a) driving forces and b) restraining forces?*

To answer these two questions, 17 semi-structured interviews were conducted with (6) Hospitalists and a selection of (11) stakeholders. These interviews were conducted between February 2013 and June 2013, all lasting 60-90 minutes. The format that was used to conduct these interviews can be found as

Appendix I. Figure 3 shows the stakeholders, the respective abbreviation used and the quantity (n) that was interviewed.

Stakeholders Interviewed

Stakeholder	Abbreviation	# Interviewees (n)
1. Hospitalist in Education	HiE	6
2. Medical Specialists	MS	3
3. Hospital Management	HM	3
4. Representative of CGS	CGS	1
5. Hospitalist Educators	EDU	2
6. Representative of Physician Assistant	PA	1
7. Representative of Nursing Specialities	NP	1
Total		**17**

Figure 3: Stakeholders Interviewed

To determine which stakeholders to interview, the stakeholder identification conducted by the University of Groningen and TGO (Toegepast GezonheidsOnderzoek centrum), the institute that was assigned to evaluate the education and implementation of Hospitalists in the pilot, was used. This stakeholder identification can be found as *Appendix II,* and was based on the model developed by Achterkamp and Vos (2007).[2]

Based on the stakeholder identification, the stakeholders that should be interviewed for this thesis were selected. These stakeholders were selected based on 1) their knowledge about the change initiative, 2) their influence on shifting professional boundaries and 3) whether they are affected by professional boundary shifting. This entails that some stakeholders are listed in the stakeholder identification, but are not interviewed for the purposes of this thesis, because 1) they are not yet knowledgeable enough to evaluate the effects the Hospitalist might have (for instance, patients) and 2) they are neither able to influence nor are they affected by professional boundary shifting. Based on the stakeholder identification and the criteria mentioned above, the following reasoning was used to select stakeholders:

(1) Defining the projects goal

The goal of creating the Hospitalist is to improve the quality of healthcare, make healthcare more efficient and improving the coordination of healthcare in hospitals. The Hospitalist should improve

[2] The authors developed a 4-step model, in which brainstorming leads to the identification of relevant stakeholders of a project. The four steps are: 1) Defining the project's goal, 2) Individual brainstorm about which stakeholders might be involved, 3) Brainstorm as a group with the purpose of identifying all the stakeholders and defining their role of involvement (Client, Decision Maker, Designer or Passively Involved), and 4) Group brainstorm to identify which stakeholders are involved in what phase of the innovation project (Initiation Phase, Development/Performance Phase, Implementation Phase or Maintenance Phase).

continuity and capacity of healthcare. This entails horizontal integration and vertical integration. To achieve this, professional boundaries of other occupations need to be shifted.

(2) Identifying stakeholders and their role (this also includes step 3)

Clients

This is the party whose purposes are being served through the project. Clients that can be identified are:

- Medical Specialists on their hospital wards (MS)

Decision Maker

Decision Makers set requirements regarding the project's process and outcomes and evaluates whether these are actually met. Decision Maker's identified are:

- Hospital Management (HM)
- CGS (College Geneeskundige Specialismen) (CGS)

Designer/Expert

A designer contributes expertise within the project and is responsible for deliverables. Designers that can be identified are:

- Hospitalists being educated now (HiE)
- Their Educators (EDU)

Passively Involved or Representative

These stakeholders are affected by the project's outcomes or process, a representative is one that speaks on their behalf. Among the passively involved are:

- Educators from medical specialties (EMS)
- Specialists (MS)
- Physician Assistants (PA)
- Specialized nursing professions (like Nurse Practitioner) (NP)

(4) Which stakeholders are involved in which phase of the project?

The project can now be considered to be in the development/performance phase. The Hospitalists have started their education in 2012, and focus is on performing the activities necessary to reach the project's goals. Although stakeholders involved right now are mostly Decision Makers and Designers, it is wise to also investigate expectations of more passively involved stakeholders in the implementation process, so potential problems or opportunities arising from these stakeholders can be anticipated on before the adoption phase. Furthermore, boundary shifting occurs with these passively involved stakeholders: boundary shifting affects stakeholders on the work floor. For most stakeholder groups,

representatives were interviewed, since most of the individual actors within stakeholder groups that will be affected were not informed yet about the project.

For anonymity purposes, these stakeholders were grouped so no quotes from interviews can be reduced back to one individual. The stakeholders were grouped as follows:

Grouped Stakeholders

Group Name	Abbreviation	Included Stakeholders	# Interviewees (n)
Hospitalist in Education	HiE	HiE	6
Specialists and Educators	SE	MS, EDU	5
Hospital Management	HM	HM	3
External Stakeholders	ESH	PA, NP, CGS	3
Total			**17**

Figure 4: Grouped Stakeholders

To increase construct validity, additional sources of data were used (Yin, 2003) Data from 3 meetings conducted between stakeholders (Concilium) was collected. These meetings were summarized and the summaries were coded with the same coding scheme as was made for the interviews. In addition to this, documents were analyzed that explained the Hospitalist's value or were used to make the educational curriculum. In addition to this, two documents were analyzed in which a stakeholder group (not represented by an interviewee) expressed their view on the change initiative, named 'De Jonge Orde': A group that acts on behalf of the doctors getting specialist education. These documents were coded like the interviews. *Figure 5* summarizes the data collection methods besides the interviews and their respective abbreviation.

Additional Data Sources

Data Source	Abbreviation
Meetings between stakeholders	MbS
Educational Curriculum	EC
Subsidy Request	SR
Essays by 'De Jonge Orde'	DJO

Figure 5: Additional Data Sources

3. *Are the identified forces a result of overlap in knowledge-, patient-, or authority-domain, or can other domains be identified?*

Rationalities identified in the previous sub-question will be investigated on whether they are resulting from boundary shifting in one of the mentioned domains, or if other domains or causes of forces can be identified. The information necessary will mainly have to come from the semi-structured interviews, which will be coded both deductively and inductively, as explained below.

3.4 Data Analysis

Data analysis was conducted by using the strategies explained by Hennink et al.'s (2011) Analytic Cycle for data preparation and code development, which is based on the Grounded Theory Approach (Glaser et al., 1967). A coding scheme was made to make coding possible. Coding of the interviews was done to facilitate the analysis. The coding process is described below.

First, verbatim transcripts were made (including everything that has been said) from the interview voice recordings. Identifiers were removed from the transcripts to preserve interviewees' anonymity. After this, the data was reduced through a combination of deductive and inductive coding, with an emphasis on the first. The deductive codes originate from the theoretical concepts described in this thesis: shifting of professional boundaries, overlap, and driving/restraining forces coming from professional identity rationality or cognitive-technical rationality. Inductive codes are derived directly from the data, thus raised by interviewees, and not predetermined by the literature review.

This method is based on Hennink et al.'s (2011) belief that a study should have a combination of deductive and inductive codes, since only having deductive codes would entail missing out on unique issues raised by interviewees, which might not have been anticipated by the researcher but could still add relevant information to literature.

Inductive coding is seen as highly important for qualitative data analysis, which can be seen in the grounded theory approach (Glaser et al., 1967). However, we follow Hennink et al.(2011) as we try to build, theory in the sense of combining pre-existing theory with new concepts, insights and findings (Liamputtong and Ezzy, 2005). In other words, in order to successfully build theory, some broad concepts need to be identified from literature (deductive coding). The reason for this is that when no concepts are identified from literature, it is difficult to understand where to look for. Given the specific goal of this research, driving and restraining forces need to be identified from the perspective of two dimensions of rationality to gain fruitful results. Deductive coding serves this purpose.

Deductive codes were created using concepts from the literature and topics from the interview guide. Inductive codes were mainly developed through reading and re-reading the transcripts for relevant issues. To the extent

that the coding was inductive, it was done until the point of saturation (Glaser et al., 1967) was reached, that is, when no more new issues could be identified that seemed relevant for identifying driving or restraining forces. After the coding scheme was developed, the first five interviews were coded, looking for flaws in the scheme or missing concepts. As emerging codes were found in the interviews, they were added to the coding scheme as inductive codes. The coding scheme can be found below as *Figure 6*. Coding was done by hand, not using a qualitative software program. To increase reliability (Baxter and Jack, 2008), the first ten interviews were coded again after 4 weeks, and codes were compared. This resulted in three codes being altered and one code being added.

After the interviews were coded, data analysis was continued by making a list of the relevant quotes found in the interviews. These quotes were matched with the theoretical concepts described in section 2 and categorized as driving and restraining forces based on cognitive-technical rationality or professional identity rationality. In addition to this, codes extracted from interviews with stakeholders were compared to look for similarities intra-stakeholder groups as well as differences inter-stakeholder groups. Yin (2003) argues that this raises internal validity and provides for deeper analysis of the findings. The results are illustrated in the next section.

Coding Scheme				
Code	***Sub-Code***	***Type***	***Code description***	***Example***
1. Overlap	**a. In Patient Domain**	Deductive	Overlap and/or boundary shifting created by the Hospitalist, that takes place in the patient domain as defined in this thesis.	*Previously, you could see different patient talking to all different kinds of doctors and nursing professions. In the future we [hospitalists] will be the ones they will first contact.'*
	b. In Knowledge Domain	Deductive	Overlap and/or boundary shifting created by the Hospitalist, that takes place in the knowledge domain as defined in this thesis.	*Although there is some knowledge on the floor, especially NP's have some, Hospitalists will have much wider and deeper knowledge.'*
	c. In Authority Domain	Deductive	Overlap and/or boundary shifting created by the Hospitalist, that takes place in the authority domain as defined in this thesis.	*Whereas now you see that doctor's assistents, who are either studying to be a specialist or are not admitted to specialist-education yet, having a supervisory role on the workfloor, Hospitalists will have that role in the future.*
	c. Other	Inductive/emergent	Overlap and/or boundary shifting created by the hospitalist, that takes place in another domain than described in this thesis.	
2. Restraining Forces	**a. Based on Cognitive-Technical rationality**	Deductive	Consequences of the created overlap that can be translated to restraining forces, based on people's cognitive-technical rationality as defined in this thesis.	*I think we should also be careful in developing to many layers of expert doctors. That could over-complicate things and make for a too complex team.'*
	b. Based on Social Identity rationality	Deductive	Consequences of the created overlap that can be translated to restraining forces, based on people's social identity rationality as defined in this thesis.	*Medical Specialists are hesitative in handing over some authority, probably because they feel their higher level of education should prevail, and they should be in charge.'*
	c. Other	Inductive	other restraining forces relevant to this research.	
3. Driving Forces	**a. Based on Cognitive-Technical rationality**	Deductive	Consequences of the created overlap that can be translated to driving forces, based on people's cognitive-technical rationality.	*It is very important in such a multi-professional context, which a hospital is, to have somebody who can look at the patient integrally and take responsibility for that patient.'*
	b. Based on Social Identity rationality	Deductive	Consequences of the created overlap that can be translated to driving forces, based on people's social identity theory rationality.	*You did not just become a doctor to make money, you want to do something for society and help patients get better: if this is what specialists need to do to improve quality of healtcare for patients, they will.'*
	c. Based on Industry Trends	Inductive	Other driving forces identified from respondents that are the result of industry.	*Because of cut-backs by the government we already saw the number of places for a specialist-education decreasing. This scarcity of places will enable us to select the best people to become Hospitalists.*
	d. Other	Inductive	Other driving forces relevant to this research.	

Figure 6: Coding Scheme

To avoid confusion on how forces were selected to be the result of Cognitive-Technical Rationality or Professional Identity Rationality, the following *Figure 7* shows criteria used to decide this, as well as actual examples. When one or more of the criteria are met, the force is categorized as the respective rationality. Interestingly, some forces could be explained by both rationalities. This will be discussed in section five.

Criteria for Rationality Selection

Rationality	Criteria	Example
Professional Identity Rationality	1. When the driving/restraining force originates from stakeholders defending their occupational boundaries. 2. When the driving/restraining force originates from a fear of role change. 3. When the driving/restraining force clearly originated because of an occupational value, or culture.	In peripheral hospitals, some specialists might feel that the Hospitalist takes away part of their job, and thus reduces their house's income.
Cognitive-Technical Rationality	1. When the driving/restraining force considers effects on the organization's functioning. 2. When the driving/restraining force considers effects on patients. 3. When the driving/restraining force considers effects on the organization's financial state.	External trends of complex patients suffering from multiple illnesses is recognized by stakeholders, Hospitalist would be able to address this patient stream more adequately than other physicians.
Both rationalities	When criteria from both Rationalities are met.	Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.

Figure 7: Categorization Criteria for Forces

4. Results

This section describes the results of the research per sub-question. Firstly, stakeholders' view on whether or not they believe professional boundaries will be shifted and if they find this a necessity for the Hospitalist to reach their full potential. Then, the driving and restraining forces from both types of rationalities will be presented and categorized with the help of the theoretical framework. The results are summarized in *Figure 8a* and *b.* The driving forces based on cognitive-technical rationality can be found from the top-left corner to the bottom-left of *Figure 8a,* and the driving forces based on professional identity rationality can be found from the top-right corner to the bottom-right. *Figure 8b* can be read the same way, but for restraining forces. The results are ordered from most often mentioned by stakeholders on top towards least often mentioned by stakeholders at the bottom. If a certain force is the result of the analysis of additional data sources, the abbreviation of this source is mentioned in the 'number of times mentioned by stakeholders' column. The abbreviation table can be found again below *Figure 8a* and *b.* Some results are categorized as belonging to both Cognitive-Technical Rationality and Professional Identity Rationality. These forces will be discussed in the next section.

4.1 Shifting Professional Boundaries and Created Overlap in Domains

Almost all stakeholders identified that professional boundaries will be shifted and overlap in tasks will be created because of the implementation of the Hospitalist. This was recognized by SEs and HMs:

> *'Now, PA's sometimes deliver the medical treatment on a ward. Hospitalists will definitely take over tasks that the PA did before.' – SE*
>
> *'It is clear that one of the results of the Hospitalist will be that internists, other medical specialists and residents will be called in consultation less often on wards where a Hospitalist is working.' – HM*

In addition to SEs and HMs, HiE also recognized the fact that professional boundaries will be shifted, like one of them put it:

> *'NPs have put themselves in the position where they are the ones having the most contact with the patient, and then calling specialists in consultation. I am not sure if this is part of their original job description, but I think this has gradually grown over time through informal delegation.' –HiE*

It can be seen in the results that overlap was created based on tasks and patient domain, but the shifting of professional boundaries is also recognized in the authority domain by HM:

> *'In the future, I clearly see a more withdrawn role for medical specialists, the coordination and responsibility for the patients than lies with, to most extent, the Hospitalist, who is the potential leader on a hospital ward.' – HM*

However, this is not recognized by all stakeholders, as a SE and a HiE argued that final responsibility and authority will always remain with the surgeon. However, other HiEs argued that specifically working for a specialist is not the intention of their job.

> *'I think that specialists will always have final authority. How this will be arranged I am not sure, but after a surgeon has performed an operation, I can't believe he will than hand over full responsibility to somebody else on the ward.' - SE*

'I think that eventually, I have to answer to the specialist on who's ward I am working at the moment…' -HiE

'It is not the intention to let specialists, surgeons for example, think that they are our boss and we do all their simple, boring tasks while they perform medical surgery… we [HiE] want to become our own discipline, not specifically working for a specialist.' - HiE

The results illustrate that stakeholders expect professional boundaries to be shifted and that overlap will be created in different domains. Next, the driving and restraining forces identified in the interviews are discussed, answering the sub-questions 1) *What cognitive-technical rationalities of stakeholders on boundary shifting and overlapping domains can be identified as (a) driving forces and (b) restraining forces?* And 2) *What professional-identity rationalities of stakeholders on boundary shifting and overlap can be identified as (a) driving forces and (b) restraining forces?*

4.2 Driving Forces

The results are summarized in *Figure 8a.*

Summary of Results

	Cognitive-Technical Rationality	# of times mentioned by stakeholders	Professional Identity Rationality	# of times mentioned by stakeholders
Driving Forces	The need for more coordination and continuity is highly recognized, which the Hospitalist would realize.	HiE: 6/6 SE: 5/5 HM: 3/3 ESH: 3/3 Total: 17/17 MbS/EV/SR	Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.	HiE: 3/6 SE: 3/5 HM: 3/3 ESH: 3/3 Total: 12/17
	External trends of complex patients suffering from multiple illnesses is recognized by stakeholders, Hospitalist would be able to address this patient stream more adequately than other physicians.	HiE: 5/6 SE: 5/5 HM: 3/3 ESH: 2/3 Total: 15/17 SR/DJO/SC	Specialists are much more likely to delegate to other doctors (Hospitalists), instead of nursing professions.	HiE: 3/6 SE: 3/5 HM: 1/3 ESH: 2/3 Total: 9/17

	Especially in small hospitals where there are not many residents, having a general doctor who can do some of the specialist's tasks will lead to more flexibility.	HiE: 4/6 SE: 4/5 HM: 2/3 ESH: 3/3 Total: 13/17	Nursing professions like having a doctor on the ward who is 'one of them', dealing with the same issues, and concerned with their work.	HiE: 4/6 SE: 3/5 HM: 1/3 ESH: 1/3 Total: 9/17
	Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.	HiE: 3/6 SE: 3/5 HM: 3/3 ESH: 3/3 Total: 12/17	Doctors did not just become specialists for the money, but to help people. If they realize that delegating is best for the patient, they will.	HiE: 2/6 SE: 3/5 HM: 2/3 ESH: 1/3 Total: 8/17
	Asking specialists in consultation for every issue is expensive, so Hospitalists reduce costs, since less specialist consultations are necessary.	HiE: 5/6 SE: 3/5 HM: 2/3 ESH: 2/3 Total: 12/17 SR	The hospitalist could ensure the interface between two paradigms in a hospital: 'We will cure you' and 'we will make your life as pleasant as possible'	HiE: 0/6 SE: 1/5 HM: 2/3 ESH: 2/3 Total: 5/17
	Most of the times, PA's, NP's and other Specialized Nurses have to ask a specialist to approve medical decisions (diagnoses, medication), which slows the entire process down. A Hospitalist would be authorized to make these decisions, and would be closer to the nursing professions, speeding up the process.	HiE: 4/6 SE: 3/5 HM: 3/3 ESH: 1/3 Total: 11/17		
	PA's, NP's and other Specialized Nurses have sometimes taken on certain tasks now, which they are not qualified for. A Hospitalist would be qualified for this work.	HiE: 4/6 SE: 3/5 HM: 3/3 ESH: 1/3 Total: 11/17 MbS		

	The unclear boundaries (positioning) for the Hospitalist makes the profession flexible at implementation: the job can entail tasks and part of domains based on local needs.	HiE: 2/6 SE: 3/5 HM: 3/3 ESH: 1/3 Total: 9/17	
	The tasks on the ward are now also done by residents, who are either not experienced enough, or lack the knowledge necessary.	HiE: 5/6 SE: 2/5 HM: 1/3 ESH: 1/3 Total: 9/17	
	Because of the overlapping domains, and the central position of the Hospitalist in this, they can take a leading role in designing better multi-disciplinary, well-coordinated treatment plans for patients.	HiE: 3/6 SE: 2/5 HM: 2/3 ESH: 3/3 Total: 9/17	
	The experience of creating a similar medical profession, the EP, can be used to guide this process. It is also argued that hospitals 'have learned from their mistakes'. HM argued that these mistakes included an initial group of EP that was too large to handle.	HiE: 2/6 SE: 4/5 HM: 3/3 ESH: 1/3 Total: 9/17	

Figure 8a: Driving Forces

Abbreviations

HiE	Hospitalist in Education
SE	Specialists and Educators
HM	Hospital Management
ESH	External Stakeholders
MbS	Meetings between stakeholders
EC	Educational Curriculum
SR	Subsidy Request
DJO	Essays by 'De Jonge Orde'

4.2.1 Cognitive-Technical rationality

It is worth noting that all stakeholders recognized the need for change based on external trends. That is, patients are becoming more complex and are more often suffering from multi-morbidity. In addition, continuity and capacity are identified as problems which the hospitalist could solve.

> '*I think we need a function as the hospitalist. A generalist who can deal with patients that are becoming more and more complex, with multiple illnesses.' - HM*
>
> *'It is clear that on some hospital wards, the continuity of health care is far from realized.' – SE*
>
> *'Our biggest contribution to health care, I think, is improving the care for complex patients, also by safeguarding continuity and quality of healthcare.' - HiE*

Based on this rationality, multiple stakeholders addressed forces that should foster the implementation of the Hospitalist. It was recognized by almost all stakeholders that there is a need for more coordination. Because of the overlap in the knowledge domains of other stakeholders that the Hospitalists will have, they will be capable of realizing this coordination: they have knowledge about multiple disciplines and are capable of performing the basic tasks. As a HM and HiE put it:

> *'They [HiE] will be able to provide coordination, because they are in the center of everybody's domain, they have knowledge from all that happens around a patient, treat them their selves or call in the necessary discipline, it's the perfect situation.' – HM*
>
> *'We will be in the center of things: the organizer of healthcare on hospital wards. Based on that position we are perfectly capable of providing the necessary coordination.' – HiE*

The fact that the hospitalist could improve coordination on hospital wards is illustrated by the following statement made by a HM:

> *'This morning I was visiting one of the wards in this hospital… Nursing professions then tell me, and they are right, that it is difficult for them because there are so many doctors: residents, getting a specialist education or not, young specialists, professors. They are dealing with a whole bunch of doctors… The Hospitalist will become their first doctor to turn to, wonderful!' - HM*

This improved coordination is not only true for situations in hospitals, but also outside hospital walls. Hospitalists will be educated in processes as handing over patients to GPs or home care. Their knowledge on these processes should improve the coordination between hospitals and other care institutions.

> *'They [HiE] will also be trained in coordinating health care outside of the hospital, they will be educated in the functioning of General Practitioners (GPs), how to hand patients over to the GPs, they will now about home care. But also the process of hiring and firing patients from hospitals will improve because of their function.' –SE*
>
> *'I think it is important for us to have a close working relationship with the GP. Health care does not stop after a patient leaves the hospital. We are most knowledgeable about the patient, also his/her situation at home. This is even more true because we are the ones talking to the patients family.' - HiE*

Close to the argument of being able to provide better coordination, is that this central position provides for improved treatment plans. Due to the overlapping domains, and the central position of the Hospitalist in this,

multi-disciplinary, well-coordinated treatment plans can be designed for patients. This was recognized by multiple stakeholders, like the HM:

> *'In a hospital, there are so many disciplines, take for instance the physical therapist, dietitian, the social worker, specialists, PAs, NPs. It is important to make a treatment plan that considers all these disciplines when a patient is complex or suffering of multi-morbidity. Designing such a well-coordinated, multi-disciplinary treatment plan will be an important task of the future hospitalists.' - SE*

One of advantages of the created overlap with specialists was recognized by multiple stakeholders. The fact that specialists have limited time, and that the Hospitalist enables specialists to do what their good at, and educated for (for instance: a surgeon can focus on his surgeries), was recognized as an important reason to use the Hospitalist. The MS's job will be more attractive as well. This can be explained as a force coming from both cognitive-technical and professional identity rationality: The organization benefits from the specialist performing surgery instead of performing basic treatment, but there are also effects for the role of a MS; a more interesting job, or as a HM put it:

> *'Their [MS] job becomes more interesting, since they do not have to do the common things anymore; instead of cleaning shoes, they [MS] get to sell them.' – HM*

Relating to this argument is the fact that asking specialists in consultation for every issue is expensive. Depending on the formal position of the Hospitalist and its level of pay, costs can be reduced when specialists do not have to come in consultation all the time. As a HM put it:

> *'When a hospitalist is employed and paid by the hospital, which seems most logical to me, the number of times a specialist will be consulted will decrease, since lots of basic medical issues can be solved by the hospitalist himself. Since then, the hospital does not have to pay a MS for his services, costs are reduced.' – HM*

When looking at shifting professional boundaries with nursing functions, PA's, NP's and other Specialized Nurses have sometimes taken on certain medical tasks now, which they are not qualified for. Various stakeholders argued that a Hospitalist would be qualified for this work.

> *'PAs sometimes do deliver medical treatment on a hospital ward… I think that's a bad situation. I believe that medical treatment should be delivered by a doctor.' – SE*
>
> *'There are so many nursing professions on hospital wards, we need a doctor there. Somebody who can carry the responsibility, diagnose, prescribe medication' –SE*
>
> *'PAs have become some sort of "handler" of consults. They consult every everybody, wave around with the advice-papers they received, and hope something good will come out of it. You really need a doctor there with general medical knowledge.'- HM*
>
> *'They [PAs, NPs] make a lot of mistakes, because they are no doctors. They perform medical tasks which they sometimes have no knowledge about. This is a dangerous situation.' - HiE*

Stakeholders also recognized that processes will be made more efficient by the Hospitalist. If, like in the above situation, nursing professions have informally been delegated some tasks in medical treatment, most of the times, PA's, NP's and other Specialized Nurses have to ask a specialist to approve medical decisions (diagnoses,

medication. This slows the whole process down. A Hospitalist would be authorized to make these decisions, and would be closer to the nursing professions, speeding up the process:

> *'Nursing professions do perform some medical tasks, at the moment. This is under strict supervision. For every little thing they have to run to a specialist to get a signature. That does not work on a ward… Sometimes you see situations where something should have been done three days ago. But it wasn't done. Either because it is not recognized, or because they have to chase down specialists for everything' - ES*

In some situations, the task of being 'the doctor on the ward' is now performed by residents. It can happen that these residents are either not experienced enough, or lack the knowledge necessary. Hospitalists would improve the quality of health care. This was argued by several stakeholders, also HiE:

> *'We can provide better coordination on a ward than residents. They lack skills, knowledge and experience. I know this, because I have been in this situation myself. I stood there with shaking hands because nobody knew what to do.' –HiE*
>
> *'Some residents, who are getting an education to become a medical specialist, are forced to take on this function as 'doctor on the ward', while in fact they don't even want to do this. They just want to learn about surgical stuff for instance, because they want to become a surgeon.' - HiE*

Multiple stakeholders argued that, especially in small hospitals where there are not many residents, having a general doctor who can do some of the specialist's tasks will lead to more flexibility, and release the specialist of some of the workload:

> '*If in small hospitals, there is like one resident working, plus a specialist, what if the resident gets sick? The specialist has to do a lot of tasks that he is overqualified for. As a Hospitalist, because you can also do some of the specialist's tasks, and the resident's task, it's not really a problem when one of them is not there.' - HiE*
>
> *'Since the trend is noticeable that the number of residents in small, peripheral hospitals is decreasing, specialists have to take on simple tasks and make crazy long shifts. A Hospitalist would be perfect here to increase flexibility' - SE*

4.2.2 Professional Identity Rationality

Based on this dimension of rationality, stakeholders identified some forces that should serve as driving forces for successful implementation of the Hospitalist. It was argued that specialists are much more likely to hand over part of their domain to other doctors (Hospitalists), instead of nursing professions, which would make the implementation easier, because MS would be happy to deal with a doctor on the ward:

> *'People with an academic education are much more recognizable in the discussion with MS. They speak the same language… they [HiE] will probably make such change initiative easier as compared to nursing professions, since nursing professions would not be recognized by MS as real health care deliverers, because they are no doctors.' - ESH*
>
> *'MS are much more likely to hand over patients if they know they will be treated well be a highly educated doctor, instead of just nursing professions.' – ES*

Although specialists would like dealing with another doctor, because they see Hospitalists as having the same professional identity, Nursing professions would like having a doctor on the ward who is 'part of them', dealing with the same issues, and concerned with their work.

> *'Nursing professions will like having a doctor on the ward who also is their "spokesperson", not only for patients, but also for the whole ward. People are just more likely to listen to a doctor than to a nurse.' - HM*
>
> *'I really recognize it when doing my job. Nurses and other people come to me saying that the really like how I take the time to talk to them, listen to what they are doing, how they would treat a certain patient, and really enjoy working on the ward. They [nursing professions] say this is the first time a doctor has shown such interest.' – HiE*

This could entail that the Hospitalist would be the perfect bridge between the professional identity of nursing professions on a hospital ward, and medical specialists. Another argument that stakeholders made is that doctors did not just become specialists for the money, but to help people. If they realize that handing over parts of their domain is best for the patient, they are more likely to cooperate.

> *'…Remember, MS are not just in it for the money. They became doctors because they wanted to cure people and deliver the best health care possible. If they see the advantages of the Hospitalist for patients, I think they will all want to work with him or her.' – HM*
>
> *'I think it is our responsibility to deliver the best quality of care that we can. If this is an improvement for patients, we should not let personal gains or losses get in the way.' - ES*

It was identified that one of the main benefits of the hospitalist could be that they provide for better treatment of patients with multi-morbidity. The hospitalist could ensure the interface between two paradigms in a hospital: 'We will cure you' and 'we will make your life as pleasant as possible'. A lot of MSs try work by the paradigm of 'curing people'. Other medical professions try to improve quality of life for patients with multi-morbidity. The hospitalist could be the bridge between these two identities:

> *'Placing an interface, a bridge between different identities, paradigms, or cultures if you will, could prove to be a great solution. This bridge would be, for instance, between internists and specialists healthcare for elderly. Those two groups don't really work well together, because of the contradicting paradigms: the internist is trying to cure, while the other is realizing that fully curing the patient is impossible, but making his life worth living is.' - ESH*

4.3 Restraining Forces

Various restraining forces based on professional identity rationality and cognitive-technical rationality were identified. The results are summarized in *Figure 8b.*

	Cognitive-Technical Rationality	# of times mentioned by stakeholders	Professional Identity Rationality	# of times mentioned by stakeholders

	It is still unclear who is going to pay for the initial costs of introducing the Hospitalist.	HiE: 4/6 SE: 3/5 HM: 2/3 ESH: 3/3 Total: 12/17 MbS	In peripheral hospitals, some specialists might feel that the Hospitalist takes away part of their job, and thus reduces their house's income.	HiE: 4/6 SE: 4/5 HM: 3/3 ESH: 2/3 Total: 13/17	
	If Hospitalists are doing all the work on a ward, there might not be enough vacancies for residents to learn this part of the job.	HiE: 3/6 SE: 4/5 HM: 2/3 ESH: 1/3 Total: 10/17	Lack of communication from initiators and HM towards other stakeholders is leading to resistant or indifferent behavior.	HiE: 4/6 SE: 3/5 HM: 0/3 ESH: 2/3 Total: 9/17	
Restraining Forces	The overlap in the knowledge Hospitalists should have with different specialties makes it difficult to choose what they should be educated in specifically.	HiE: 2/6 SE: 4/5 HM: 1/3 ESH: 1/3 Total: 8/17	Specialists naturally feel responsible for their patients, it is doubtful whether they will hand this over to somebody else.	HiE: 4/6 SE: 4/5 HM: 2/3 ESH: 1/3 Total: 11/17	
	Taking the opportunities away for doctors to select promising residents based on their work on a ward.	HiE: 0/6 SE: 5/5 HM: 2/3 ESH: 1/3 Total: 7/17	Some tasks in the Hospitalist's job description are being done by PA's, NP's and other Specialized Nurses, they might protect that domain. Especially when the Hospitalist's domain boundaries (positioning) are unclear.	HiE: 4/6 SE: 2/5 HM: 2/3 ESH: 2/3 Total: 10/17 DJO	
	Underestimating of the importance of clear positioning of the Hospitalist. It can be argued that postioning is necessary (see Discussion).	HiE: 2/6 SE: 2/5 HM: 2/3 ESH: 0/3 Total: 6/17	If the Hospitalist is seen as of lower 'status' than a specialist, it is doubtful whether the specialists will delegate responsibilities.	HiE: 3/6 SE: 2/5 HM: 1/3 ESH: 1/3 Total: 7/17	

		Difficulty of breaking through the paradigm of 'curing people' towards providing them with a higher quality of life.
		HiE: 0/6 SE: 1/5 HM: 1/3 ESH: 1/3 Total: 3/17

Figure 8b: Restraining Forces

Abbreviations

HiE	Hospitalist in Education
SE	Specialists and Educators
HM	Hospital Management
ESH	External Stakeholders
MbS	Meetings between stakeholders
EC	Educational Curriculum
SR	Subsidy Request
DJO	Essays by 'De Jonge Orde'

4.3.1 Cognitive-technical rationality

Some of the HMs and MSs interviewed recognized that if Hospitalists are doing all the work on a ward, there might not be enough place for residents to learn this part of the job. Furthermore, it was recognized by some SEs that the hospitalist takes away the opportunity for specialists to select promising residents based on their work on a ward:

> *'It is a potential danger that in hospitals where Hospitalists are working, residents do not learn what the working on a ward is like, because the hospitalists are doing all the work there. If they come to work in another hospital, where there is no hospitalist active, they it might be necessary that they do perform these tasks.' – HM*
>
> *'We have to beware that Hospitalists do not stand in the way of us educating our residents, when they are doing all the work on the ward.' - SE*
>
> *'We [ESs] used functioning on a ward as the first encounter with residents looking for specialist education. It was used to select which ones they want and which ones they don't. That was a pretty good method.' - SE*

In addition to this, multiple issues can be identified when considering how the Hospitalist should be positioned exactly. Firstly, it seems unclear exactly how the Hospitalist will be positioned in a hospital. Obviously, the positioning of the Hospitalist has influence on which professional boundaries are shifted and where overlap is created.

> *'We don't know yet how the hospitalist will be positioned exactly. That is, what exact tasks they are going to get, what responsibilities they will get. Also formally this has not been decided yet.' - HM*
>
> *'The exact positioning is something that still needs to be figured out.' – ESH*

To go even one step further, it was identified that stakeholders had different ideas about this, and that there is also doubt amongst Hospitalists:

'There is no way to kill this initiative quicker than by making specialists responsible for the hospitalists' – HM

'I think in the end, Hospitalists will always answer to a specialist.' – ES

'It is still a bit vague on what position we will get exactly in hospitals, whether we will work as 'doctors on a ward', in which case we would take over a lot of tasks from PAs and NPs, or above those, as some sort of health care manager, in a more supervising role.' – HiE

Secondly, differences exist on whether predefining the exact position is necessary, or if it is something that should gradually evolve after implementation. Various stakeholders provide different arguments about whether or not the HiE's professional boundaries should be defined clearly. This discussion seems to be subject to competing rationalities. One could argue that from cognitive-technical rationality, vague professional boundaries can be perceived as a driving force. This is because no clear positioning enhances flexibility of implementation, since the Hospitalist will take on roles which are demanded locally. However, it could also be argued that no clear positioning would entail that the Hospitalist will never take on his intended role in a hospital. In addition to this, other professions might show more resistance since they have no idea which domains the Hospitalist will enter. These arguments would originate from professional identity rationality.

'*You have to position them [HiE] well, which tasks they are responsible for and which not. I think you have to be careful. It should be clear which issues they may solve themselves, and for which issues they should consult a specialist.' – ES*

'You always have people resisting such an initiative and people embracing it that will develop over time. We'll just see how it goes. That's why we deliberately did not give the hospitalist a clear position. They can figure that out locally.' - HM

'Maybe the HiE will take over tasks from other professions; we will see that in the future. I don't feel like debating every scenario and having a big discussion about in advance.' - ESH

The overlap in the knowledge Hospitalists should have with different specialisms makes it difficult to choose what they should be educated in specifically. Stakeholders addressed this fact by arguing that other internships should be part of the educations, or that some internships should be longer. Like one SE put it:

'I would have like to see some different things in the curriculum. For instance, an internship about how consultation works, or more information about how the organization of a hospital ward works.' –SE

This is also recognized by Hospitalists themselves:

'Because we have to gain knowledge about so many disciplines, some internships are rather short. Internal Healthcare for instance, is just one year. This is too short. I get the feeling everything had to be pushed into three years.' - HiE

4.3.2 Professional Identity Rationality

Different restraining forces based on professional identity rationality were identified by interviewing the stakeholders. Some specialists feel that the Hospitalist takes away part of their job, and thus reduces their house's income. In addition to that, some tasks in the Hospitalist's job description are being done by PA's, NP's and other Specialized Nurse; they might want to protect that domain.

'Specialists make a lot of money with consults. They could see the hospitalist taking over these tasks as people taking bread out of their mouths.' -SE

'It is clear that PAs and NPs had to fight hard to get in the position that they are now: being able to also deliver medical treatment to patients, do some diagnosing and prescribing medication themselves. It is only logical they will resist us taking this from them.' - HiE

'I met a PA who was very scared. Not only was he scared to lose some tasks, but also to lose their whole job.' - HiE

Several stakeholders complained about the lack of communication from initiators to other stakeholders. HiEs, SEs and ESH argued that they want to be more involved in the design process. If that would not be possible, than they at least want to be informed:

'…No I was not involved in any way until it was already decided that Hospitalists would be working in this house. Yes, I do think that it would have been nice to at least give me a heads-up…' -SEs

It was argued by multiple stakeholders that specialists naturally feel responsible for their patients; it is doubtful whether they will hand this over to somebody else. Especially if the Hospitalist is seen as of lower 'status' than a specialist, it is doubtful whether the specialists will hand over tasks and responsibilities, and treat hospitalists as equals.

'If it will be the case that specialists should hand over authority to somebody else, resistance might occur. Specialists naturally do not like this.' - HM

'Patients are there for the specialist, not for the hospitalist. After surgery, the surgeon is responsible for what happens, not anybody else.' - SE

'It's funny, my mom is a MS, and the moment I told her I was going to be a Hospitalist, the first thing she said was: "so you won't be a specialist". I tried to explain her that I would get higher education for this, and explained the necessity of this profession. Although she seemed to understand, I still think she thought of the function as "lower" than a MS.' – HiE

'With all due respect, I see the Hospitalist as a function in which you are, to say it a little bit belittling, a subject, always following. There is nothing wrong with that, but you are not the one in the frontline, the pioneer, like MS. I think it has to do with MS having higher ambitions, and wanting to be responsible in the end.' -SE

'I do feel MS here looking at me differently than at other residents. Sometimes they tell me: "oh you don't have to know this, you are only going to be a Hospitalist", almost like they are better or higher than me.' - HiE

Furthermore, it was identified that one of the main benefits of the Hospitalist is that the role suits the trend of more complex patients suffering from multi-morbidity. However, doctors in hospitals work by the paradigm of 'curing people'. Patients suffering from multi-morbidity often cannot be cured, but who's live can be made worth living. This is something that should be done by dialogue with the patient: shared decision making. The hospitalist should play a central role in this. However, to be able to do this, the Hospitalist should break through

that paradigm of 'curing patients'. This breaking through the paradigm of 'curing people' towards providing them with a better way of living, can be extremely difficult:

> '*The paradigm of doctors trying to 'cure patients' is extremely strong. If those patients are suffering from multi-morbidity, and eight doctors are trying to cure every illness they have, problems might arise. Counterproductive actions are unfortunately not a scarcity. The Hospitalist should not be part of this paradigm, and believe me, that will be difficult. Especially because most of the educators of the hospitalist do operate according to this paradigm..' - ESH*

4.4 Differences found between hospitals

Stakeholders argued that there are differences between small-peripheral hospitals and large-academic hospitals. One argument that was made is that implementation of Hospitalists is more likely to be successful in Academic hospitals, since all doctors are employed by the hospital. The specialists are not, like in most peripheral hospitals, self-employed. This means that the hospitalist does not reduce the specialist's income in this case:

> '*I think it's smart to first implement the hospitalists in academic hospitals, here are specialists much more likely to adopt them, since it won't take anything away from their salary.' - HM*

Another issue that was raised is that the value of Hospitalists could be higher in small-peripheral hospitals than in academic hospitals:

> *'In academic hospitals, there are so many disciplines walking around that hospitalists tasks can easily be done by a combination of all those disciplines: residents, nursing professions and specialists.' – SE*

As a consequence of that large number of disciplines, implementation might be more difficult, as was stressed by the following stakeholder:

> '*Look, in academic hospitals, there are so many disciplines working on a hospital ward. I think the value of Hospitalists there is lower… also, it might be more logical to see resistance there from all the nursing professions and especially from residents.' – SE*

In addition to this, some stakeholders claimed that patients in academic hospitals were often too complex to be treated by a hospitalist:

> *'In academic hospitals, patients are so extremely complex, that you need to make use of extremely specialized doctors. I am wondering whether there is a place for the hospitalist there.' – SE*

On the other hand, other stakeholders claimed that especially in those cases, the hospitalist would be the coordinator of the whole process:

> *'Especially when patients are very complex, and you only have these extremely specialized doctors treating them [patients], the role of coordinator, performed by the hospitalist, is crucial.' - HM*

These results are summarized in *Figure 9.*

Arguments	Small-Peripheral	Large-Acadamic
All doctors are paid by the hospital, less resistance since specialist's income is not reduced.	Con	Pro
Complex patients have extremely specialized doctors. The coordinating [Hospitalist] role is curcial.	Con	Pro
Less residents and nursing professions in small peripheral hospitals means a higher expected value their for Hospitalists.	Pro	Con
Implementation difficulties because of the large number of professions.	Pro	Con
Patients in large-academic hospitals are too complex to be treated by a Hospitalist.	Pro	Con

Figure 9:Perceived Pro's and Con's of Hospitalists in Small-Peripheral and Large-Academic Hospitals

5. Discussion

This section discusses and concludes this research by firstly summarizing the results in a FFA. Secondly, based on the findings depicted in the FFA, this study's theoretical implications are evaluated by developing propositions.

DRIVING FORCES	Likelihood of Professional Boundary Shifting	RESTRAINING FORCES

Then, this paper's practical implications and recommendations are discussed. Fourthly, this study's limitations are considered. Finally, a conclusion is drawn to indicate key contributions.

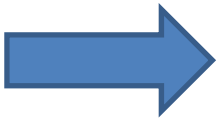
5.1 FFA

Figure 10 depicts the FFA, answering the main research question. The driving and restraining forces are stated and given one of three different sized arrows, ranging from small, weak or unimportant to large, strong and important. This was done by 1) measuring the strength of the forces by counting the number of stakeholders that addressed the force, 2) selecting crucial conditions, like financing of the project: if there is no financing, the profession is never going to diffuse, and 3) selecting the most interesting forces to discuss, based on the contribution these forces make for theory and practice.

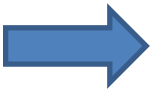
Cognitive Technical Rationality

The need for more coordination and continuity is highly recognized, which the Hospitalist would realize.

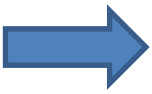
External trends of complex patients suffering from multiple illnesses is recognized by stakeholders, Hospitalist would be able to address this patient stream more adequately than other physicians.



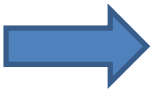
Especially in small hospitals where there are not many residents, having a general doctor who can do some of the specialist's tasks will lead to more flexibility.



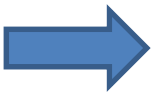
Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.



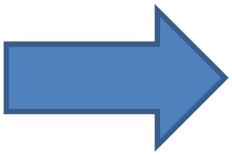
Asking specialists in consultation for every issue is expensive, so Hospitalists reduce costs, since less specialist consultations are necessary.



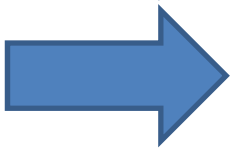
Most of the times, PA's, NP's and other Specialized Nurses have to ask a specialist to approve medical decisions (diagnoses, medication), which slows the entire process down. A Hospitalist would be authorized to make these decisions, and would be closer to the nursing professions, speeding up the process.



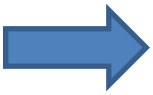
PA's, NP's and other Specialized Nurses have sometimes taken on certain tasks now, which they are not qualified for. A Hospitalist would be qualified for this work.



The unclear boundaries (positioning) for the Hospitalist makes the profession flexible at implementation: the job can entail tasks and part of domains based on local needs.



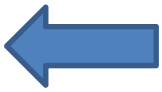
The tasks on the ward are now also done by residents, who are either not experienced enough, or lack the knowledge necessary.



The experience of creating a similar medical profession, the EP, can be used to guide this process. It is also argued that hospitals 'have learned from their mistakes'. HM argued that these mistakes included an initial group of EP that was too large to handle.

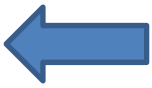
It is still unclear who is going to pay for the initial costs of introducing the Hospitalist.

If Hospitalists are doing all the work on a ward, there might not be enough vacancies for residents to learn this part of the job.



The overlap in the knowledge Hospitalists should have with different specialties makes it difficult to choose what they should be educated in specifically.

Taking the opportunities away for doctors to select promising residents based on their work on a ward.



Underestimating of the importance of clear positioning of the Hospitalist. It can be argued that postioning is necessary (see Discussion).

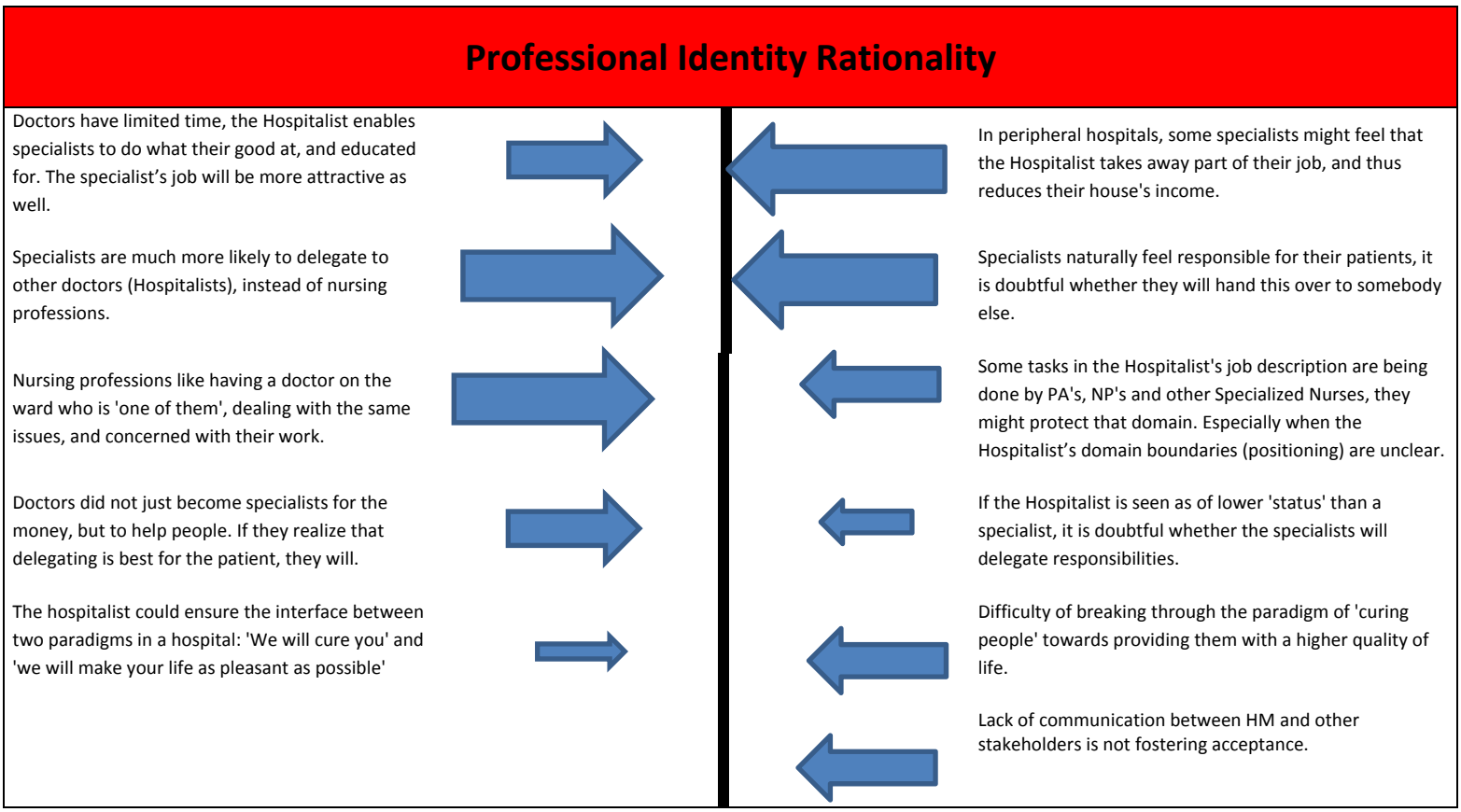


Figure 10: Force Field Analysis

This FFA is the answer to the main research question. This thesis intended to identify forces influencing the future implementation of a new medical profession in an institutionalized, multi-professional context. In this case study, stakeholders were asked to give their opinion about the new medical profession: the hospitalist, and its effect on professional boundaries shifting and overlap. These views on and opinions about the potentially shifting of professional boundaries and created overlap, was looked at from two dimensions of rationality: cognitive-technical rationality and professional identity-rationality.

It was found that both dimensions of rationality accounted for multiple driving and restraining forces. It can be seen in the FFA above that cognitive-technical rationality accounts for most forces, and also the strongest forces (which can be seen from the size of the arrows; large, medium and small). Findings show that all stakeholders consider professional boundary shifting and overlap creation from both dimensions of rationality. Thus, as was expected, the rationalized myth of how stakeholders see the change initiative is the

result of multiple dimensions of rationality, which can reinforce each other or conflict with each other (Townley, 2002).

Multiple issues have been identified which are worth discussing in this section. Also, the third sub-question of this research will be discussed in this part of the discussion: *Are the identified forces mentioned above a result of overlap in knowledge-, patient-, or authority-domain, or can other domains or causes be identified?*

First of all, the ratio between cognitive-technical forces and professional identity forces is addressed. Secondly, the absence of a distinction in patient-, knowledge-, and authority-domains is explained. Then, this section discusses professional identity as a driver for change. Fourthly, the disagreement on the positioning of the Hospitalist is elaborated on. In addition, important differences between Large-Academic and Small-Peripheral Hospitals are discussed.

5.1.1 Cognitive Technical Rationality vs. Professional Identity Rationality

As was already stated above, based on this FFA, cognitive-technical rationality seems to explain most of the forces as compared to professional identity rationality. This could be due to multiple reasons. 1) Initiators and managers have successfully convinced most stakeholders that this initiative is a certain step forward for hospitals, and the stakeholders are committed to improving health care. However, Cawsey et al. argue that when assessing a change, people are more likely to put their own needs above the organization's needs. It could be though, that this is different for health care organizations specifically. Furthermore, the results show a clear lack of communication towards and involvement of stakeholders by initiators and hospital managers. This makes it unlikely that all stakeholders are convinced to put the organization's needs above their own. 2) Another reason could be that stakeholders do not know all the consequences of the new profession for them yet, and are only repeating what management has told them. In this case, professional identity rationality would be more present in a later phase of the change project, close to implementation. However, this FFA shows that cognitive-technical rationality explains most of the forces influencing the implementation of the Hospitalist, so this study proposes the following:

P1: Cognitive-technical rationality is capable of explaining more of the forces in play when introducing new clinical professions than professional identity rationality.

5.1.2 Patient-, Knowledge-, and Authority-domains

Kathan-Selck and Van Offenbeek (2010) have argued that overlap and boundary shifting can occur in the patient-, knowledge-, and authority-domain. This thesis did not find the required evidence to support these findings, although in some cases, domains were specifically mentioned or could be identified. Hospitalists need to build on the knowledge of other specialties is clearly overlap in knowledge-domain. However, when surgeons are handing over routine patient care and responsibility to Hospitalists, it seems difficult to define whether this is the shifting of professional boundaries in the patient-domain, the authority-domain, or both. Categorizing based on rationalities and domains seems to only make the situation over-complex. Another explanation could be that because the role of the hospitalist has no clear boundaries yet, it is more difficult to assess which domain boundaries are going to be shifted.

5.1.3 Professional Identity as a driver for change

From literature (Kenny et al. 2011) it was expected that based on professional identity rationality, mostly restraining forces would emerge. Mostly because other disciplines would be expected to defend their professional boundaries against other professions entering their domains. Although this effect was recognized by stakeholders, this thesis proposes another effect that might occur based on predictions of stakeholders: specialists and nursing professions might be very receptive to 'a doctor on the ward'. For specialists, this would be the case because of two reasons: 1) Hospitalists, being academically educated doctors, are much more recognizable in the discussion with specialists, because they have the same professional identity, or 'they speak the same language', as compared to nursing professions or residents performing the same tasks. This is crucial for a profession like the Hospitalist, since it requires horizontal integration, which cannot be achieved without professional boundary shifting. If you are more recognizable in the discussion, it is much more likely that boundaries will be shifted. Also, 2) specialist's identity of doing 'what is best for the patient' might push them towards accepting the initiative and delegating parts of their domain, and patients, to Hospitalists, if they realize this would improve the quality of healthcare.

For nursing professions, it was identified that they would appreciate having a doctor on their turf, somebody that 'belongs' to their group, who could serve as a 'spokesperson' for them: A highly educated doctor who is committed to the work on a hospital ward, and is capable of recognizing problems and making those problems open for discussion.

Based on the above, academically educated doctors who become part of a group nursing professions, could form a bridge between specialists and nursing professions, thus enabling better communication between the two. The following proposition is presented:

P2. When introducing a new clinical profession to enhance horizontal integration, having an academically educated doctor in a position increases the change of boundaries being shifted.

5.1.4 Disagreement on the positioning of the Hospitalist

As can be seen in the results, there is disagreement amongst stakeholders on how the hospitalist should be positioned, and whether they should be positioned at all, or if positioning is something that should be gradually evolving over time in a local setting. It seems that these contradicting views can be explained by the multiple rationalities approach used in this thesis. One might argue, for instance, that implementation is easier when the Hospitalist has unclear boundaries, since than the Hospitalist's role will be adjusted to local needs (Wallace and Schneller, 2008). This is a driving force resulting from cognitive-technical rationality. However, for the Hospitalist role itself it could prove to be disastrous, since they might not be able to perform the job they have been educated for. In addition, the uncertainty for other stakeholders about what is going to change for them could result in resistance (Cawsey, 2010). These are more related to professional identity rationality. This shows that basically the same change procedure can be looked at from totally different points of view, or rationalities.

Although there is disagreement, there seems to be consensus on the fact that if the Hospitalist is to reach its full potential, professional boundaries have to be shifted and overlap with other functions has to be created. Kathan-Selck and Van Offenbeek (2010) have identified in their research that when small groups of new doctors are gradually implemented through a process of socio-political conflict, the new profession assimilates into existing structures rather than boundaries being shifted. Since lots of HMs in this case seem to assume hospitalists will gradually evolve into their intended role, the result might be that the Hospitalist will not be able to realize their added value. However, Wallace and Schneller (2008) have found that a process which the authors describe as 'orchestrating' works best. This tactic does not include the rigid positioning of a role, but rather focuses on local flexibility. This method was identified as very successful when implementing the Hospitalist in US hospitals. Further research is needed on this specific subject to contribute to theory and practice. This thesis suggests the comparison of the 'orchestrating' method by Wallace and Schneller (2008) and the more rigid positioning to ensure professional boundaries will shift as proposed by Kathan-Selck and Van Offenbeek (2010), since both forces are found in this research by using conflicting rationalities. A possible reason could be that because the Hospitalists in the US were very experienced internists, they are better able to 'fight' for their piece of a certain domain than young doctors just out of school. This would entail that, in the process of socio-political conflict, the more experienced internists are able to take the role they are intended to have, while young doctors are not able to. Another reason could be that the number of Hospitalists in the US was immediately increasing rapidly. Managers communicated experience and information quickly and were

able to excite other hospitals (Wallace and Schneller, 2008; Wachter, 2006), thus vastly engaging more Hospitalists and reporting positive results early on.

5.1.5 Large-Academic vs. Small-Peripheral Hospitals

The results show that stakeholders have contradicting views on the difference between implementing the Hospitalist in either academic hospitals or peripheral hospitals. Stakeholders seem to agree on the fact that implementation could be easier in academic hospitals, since specialist's income will not be reduced. However, it is also argued that because of the large number of different professions in academic hospitals, more professional boundaries need to be shifted and implementation is more difficult.

Most stakeholders argued that benefits of the Hospitalist are larger in small-peripheral hospitals than in academic hospitals, because they provide flexibility and an increase in both continuity and capacity. Benefits for specialist's are also present: because of the low number of residents in peripheral hospitals, specialist's perform tasks they are over-qualified for and work extremely long shifts. This would mean implementation would be easier in peripheral hospitals, because of the fact that less professional boundaries need to be shifted, and more benefits are recognized. Based on this, the following proposition is made:

P3. Implementing a new medical profession that entails vertical differentiation and horizontal integration is easier in peripheral hospitals than in academic hospitals.

5.2 Practical Implications and Recommendations

This thesis proposes that hospital managers, when assessing the likelihood of success for a new medical profession, should analyze the hospital's readiness for shifting professional boundaries and deliberately creating some overlap. This boundary shifting was found to be necessary for the new medical profession, the Hospitalist, to realize its potential added value. It is proposed that managers do not analyze this uni-dimensionally. Rather, it should be realized that multiple dimensions of rationality contribute to the rationalized myth: how one sees a certain change initiative. For conducting FFA, taking the perspective of multi-rationality provides for deeper insights on forces, their origin and possible remedies.

Specifically for the Hospitalist-case, this thesis proposes that when, like in this case, a small number of new medical professionals are introduced in an institutionalized, multi-professional context, positioning and boundary setting should be strict, clear and well-communicated. Only then will shifting of professional

boundaries occur, as identified by Kathan-Selck and Van Offenbeek (2010), instead of the new job assimilating into existing structures and procedures. However, from literature it can also be seen that the assimilating tactic was often used in the US, and has arguably been very successful (Wallace and Schneller, 2008). This thesis has found stakeholders considering both forces. Further research is necessary, specifically comparing the two methods. However, since the Hospitalist case looks more like the SEH-case analyzed by Kathan-Selck and Van Offenbeek (2010) than the Hospitalist case in the US (more experienced, larger group of Hospitalists), I would propose strict, clear and well-communicated boundary setting, to avoid the Hospitalist not achieving its intended role.

Furthermore, multiple stakeholders have addressed problems with communication and non-involvement in the project. While documents stated that Hospitalists in education would be co-designers of the profession, it is claimed that this is not the case. Also other stakeholders have addressed the lack of information and involvement. Ironically, it is argued by multiple authors that it is exactly the communication and involvement that fostered acceptance the most. For instance, Wallace and Schneller (2008) describe an intervention where physicians are asked to work as a Hospitalist for a day or two. These kinds of interventions have proven to be successful in raising awareness and reducing resistance.

In addition to this, it might be wise to implement in small-peripheral hospitals first, since that is where benefits are perceived to be the highest, and less professional boundaries need to be shifted because of the lower number of residents and nursing professions as compared to academic hospitals.

Finally, the last recommendation is one that has proven useful in the US, and has also been mentioned by a few stakeholders during data collection, is finding the support of powerful stakeholder groups (Wallace and Schneller, 2008) like the internists in the Netherlands. Having their back-up has proven to help overcome resistance by other stakeholders.

5.3 Limitations

A few limitations apply to this study. First, the author has no medical background. The FFA is solely based on the arguments stakeholders presented, and these were taken for granted. This means that what was argued to be an improved in quality and continuity is assumed to be true. However, the researcher could draw upon the Thomas Theorema. This theorem suggests that what people in an organization define a situation to be true, the consequences will be true. Secondly, because of the fact that this is a single case study with embedded sub-units, and extensive analysis could be made of this case, but not very generalizable to other cases. Further research should focus on testing the proposed multiple-rationality method of making FFA in different contexts and more cases. Thirdly, because of the small number of stakeholders that could be interviewed, no pilot

interview was conducted. All stakeholders that could be interviewed were used for the data collection. However, two questioned were dropped out of the interview protocol after two interviews because they were almost identical to other questions. Finally, measurement of the strength of the forces was done by simply counting the number of stakeholders that mentioned them and which were perceived as most important by the researcher. More extensive methods of measuring the strength of forces exist. Salaheldin (2003) measured the relative strength of forces previously identified quantitatively. This thesis proposes that the relative strength of driving/restraining forces identified in this thesis is measured, to investigate which are perceived as most important. After this, more can be said about the ratio between the multiple rationalities.

5.4 Conclusion

This thesis analyzed the readiness for shifting professional boundaries, in the case of the Hospitalist in the Netherlands, by conducted a multiple-rationality FFA. Driving and Restraining Forces were identified as originating from cognitive-technical rationality, professional identity rationality, or both. The two-dimensional view seems to provide deeper insights in some forces. Positioning the Hospitalist seems to be the major topic for discussion among stakeholders, and analyzing this two-dimensionally provided 1) more information about the origins of the force and possible remedies and 2) an explanation of why people view certain forces differently than others.

This research has found that whether or not professional boundaries will be shifted also depends on the identity of the new profession and the other occupations on the work floor. In addition to this, whether implementation is done in large-academic hospitals or small-peripheral hospitals also seems to influence the outcomes of employing a Hospitalist.

Although on most of the issues raised in this discussion section, no clear answer can be given, it should be clear that taking a multi-rationality perspective when assessing readiness for change, new insights on the dynamic of complicated institutionalized change can be identified.

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7.Appendices

Appendix I: Interview Protocol

SEMIGESTRUCTUREERD INTERVIEWSCHEMA ZHA

VOORBEREIDING

1. Voorstellen
2. Toelichting onderzoek
3. Tijd beschikbaar voor interview
4. Anonimiteit[3]
5. Toestemming opname

ACHTERGONDKENMERKEN

Alle stakeholders

1. Functie en organisatie
2. Rol/positie tav functie ZHA (niet voor ZHA)
3. Bij ZHA: motivatie en achtergrond

ALGEMEEN, INTRODUCEREND

Alle stakeholders

Wat is volgens u het primaire doel van het gaan opleiden van ZHA-en?

1. Wat zijn afgeleide of bijkomende doelen?
2. In hoeverre bestaat hier voor uw gevoel consensus over bij alle betrokkenen (probing: in 't veld tussen de ziekenhuizen, tussen beroepsgroepen, tussen VWS en het veld, binnen uw eigen ziekenhuis)?
3. Wat is uw eigen, persoonlijke visie op de mogelijke toegevoegde waarde van deze nieuwe medische beroepsgroep?
4. [In hoeverre zijn er binnen uw ziekenhuis al ervaringen met het inzetten van de ziekenhuisarts of eventueel andere nieuwe functies (zoals de PA, Np)? Zo ja, welke? Wat kunnen we daarvan leren?

STAKEHOLDERSANALYSE

[3] Uitleggen dat de gegevens ip anoniem worden verwerkt. Door het kleine aantal stakeholders per groep kan soms desondanks worden achterhaald wie wat heeft gezegd. De interviews worden getranscribeerd en voorgelegd aan de geïnterviewde, waarbij de mogelijkheid wordt geboden om op die momenten dat mogelijk te achterhalen is wie wat heeft gezegd en dat niet gewenst is, deze tekstfragmenten te verwijderen.

Alle stakeholders

Ik wil nu een aantal vragen stellen die specifiek ingaan op het perspectief van u als [stakeholdergroep].

1. Op welke manier bent u betrokken bij en/of geïnteresseerd in het inzetten van de ZHA?
2. Verwacht u (later: merkt u) dat het inzetten van de ZHA positieve invloeden op uw werkzaamheden heeft?
3. Heeft het inzetten van de ZHA ook negatieve gevolgen voor uw werkzaamheden?
4. Welke positieve en negatieve effecten verwacht u dat de invoering van de ZHA in Nederlandse ziekenhuizen zal hebben voor [uw stakeholdersgroep]?
5. Op welke manier zou u baat kunnen hebben (korte en lange termijn, inhoudelijk of betrekkingsniveau) bij het inzetten van de ZHA?
6. Wat ziet u als de kritieke bijdrage aan het slagen van de functie ZHA vanuit [uw stakeholdergroep]?
7. Wat is ervoor nodig om te zorgen dat die bijdrage ook geleverd wordt/blijft worden?

COGNITIEF TECHNISCHE KRACHTEN

Primaire stakeholders, muv bestuurlijk en medisch management

1. Ontwikkeling functie ZHA

Alle stakeholders, vraag 1 en 2, 7-9 alleen primaire stakeholders

Volgens de SOZG (Stichting Opleiding Ziekenhuisgeneeskunde) is het doel van het ontwikkelen en uittesten van de functie van ZHA "het verbeteren van de continuïteit van zorg en het efficiënter inzetten van de capaciteit van specialistische zorg".

Over beide doelstellingen heb ik de volgende vragen:

1. In hoeverre voldoet de opleiding (theoretisch en praktisch), zoals deze nu verloopt, aan de voorwaarden om de continuïteit in zorg te realiseren? Denk aan kennis, vaardigheden, samenwerking met andere disciplines, supervisie.?
2. In hoeverre voldoet de opleiding (theoretisch en praktisch), zoals deze nu verloopt voor het efficiënter inzetten van de capaciteit van de specialistische zorg?
3. Wat verwacht u meer in het algemeen van de impact van de ZHA op de kwaliteit van zorg voor patiënten? Specificeren wat kwaliteit van zorg is. Op welke terreinen verwacht u een verbetering, en op welke terreinen een bedreiging en waarom?
4. Hoe vindt u het huidige functioneren van de ZHA-en? (probing:Verschilt dit sterk of niet per persoon?)
5. In hoeverre denkt u dat de huidige ZHA na afronding van de opleiding kunnen voldoen aan het realiseren van bovenstaande doelen?
6. Wat verwacht u van de impact die u als ZHA zult hebben voor aangrenzende functies (bv specialisten, arts-assistenten, verpleegkundigen, 1^{e} lijn (taken, verantwoordelijkheden, bevoegdheden, afstemming van het werk, workload)?
7. Voor welke functies verwacht u verbeteringen/kansen?
8. Voor welke een bedreiging/risico en waarom?

Een derde geformuleerd doel betreft het bieden van een ander type loopbaan aan afgestudeerde artsen.

9. Wat zijn in theorie de persoonlijke doelen, ontplooiingskansen, carrièreperspectief (aantrekkelijkheid van de functie) voor de ZHA?
10. Ziet u dat ook terug cq. past dat bij de functie van ZHA zoals die nu wordt vormgegeven?
11. Zijn de randvoorwaarden (parttime werken, meer generalistische taken) om dat mogelijk te maken gerealiseerd binnen de ZH-en en binnen NL?

ORGANISATORISCHE CONTEXT (SOCIAAL POLITIEKE OMGEVING)

Taken en verantwoordelijkheden

Primaire stakeholders

1. Wat wordt, denkt u, de formele positie van de ZHA binnen het ziekenhuis (kennis, expertise, autoriteit)?
2. Zijn er institutionele randvoorwaarden die moeten worden vervuld voordat iemand als ZHA kan worden aangesteld binnen dit ziekenhuis?
3. Welke concrete rollen (TBV, en werkplek) verwacht u dat ZHA-en in de toekomst zullen gaan vervullen in NL ziekenhuizen?
4. En verwacht u dat de eerste generatie ZHA-en deze rollen gaat vervullen, specifiek binnen uw eigen ziekenhuis? Waarom wel/niet?
5. Wat zijn de belangrijkste voordelen (opbrengsten) van het op deze manier inzetten van ZHA-en?
6. Zijn er volgens u ook nadelen of risico's verbonden aan het op deze manier(en) inzetten van ZHA-en (financiën/verdeling geld, autoriteit, verantwoordelijkheid patienten)?
7. Ontstaat er overlap in taken, verantwoordelijkheden en bevoegdheden met andere specialisten en disciplines? Tot welke knelpunten kan dat leiden?
8. Op welke manier wordt of zou de samenwerking van de ziekenhuisarts met aanpalende functies moeten worden vormgegeven? Hebt u vertrouwen in die aanpak?
9. Bestaat er binnen de afdeling waarbij u betrokken bent een gezamenlijke visie over de manier waarop de ZHA wordt ingezet en ondersteund?
10. Hoe kan de functie van ZHA worden ingebed in de bestaande werkstructuur van het ziekenhuis?

Draagvlak binnen betrokken afdeling(en)

Primaire stakeholders

1. Bestaat er binnen de afdeling/organisatie (bij verschillende medewerkers) draagvlak voor het invoeren van de ZHA en wordt de visie over de invulling gedeeld (compatibility)?

2. Is de afdeling/het ziekenhuis in de afgelopen jaren betrokken geweest bij andere veranderingen binnen de werkstructuur?
3. Hoe is de samenwerking en het onderlinge vertrouwen tussen de betrokken afdelingen?
4. Bestaat er binnen het ziekenhuis/de afdeling een verandercultuur, dus worden veranderingen ondersteund en gestimuleerd?
5. Is er onder de betrokken medewerkers voldoende tijd en draagkracht om aan het inzetten van de ZHA mee te werken?
6. Wordt de meerwaarde van het inzetten van de ZHA gezien door betrokken medewerkers (relative advantage)?
7. In hoeverre is deze verandering uitvoerbaar? Dus is er veel nodig om de inzet van de ZHA te realiseren of zijn er veel potentiele barrières (complexity)?
8. Op welke manier zijn medewerkers geïnformeerd of betrokken bij het invoeren van de functie van ZHA (diffusie)?
9. Signaleert u tegenstrijdige belangen?

PROCESEVALUATIE

Primaire stakeholders (muv vraag 1 en 2 voor ziekenhuisartsen)

De volgende vragen gaan over het voorbereidingstraject voor het inzetten van de ZHA.

1. Hoe is de samenwerkingsovereenkomst tot stand gekomen? En hebben er nog veranderingen plaatsgevonden in deze overeenkomst?
2. Het opleiden van ZHA-en is in het verleden al eerder geprobeerd, in ieder geval binnen het UMCG, maar niet doorgezet. Waarom nu (weer) opgepakt? In hoeverre zijn de omstandigheden nu anders dan toen?
3. Wordt het opleidingsplan zoals dat is ontwikkeld gevolgd. Zo niet, waarin wordt van het plan afgeweken en wat is daarvan de reden? Verschillen ziekenhuizen daarin? Hoe? (MO)
4. Wat bepaalt of het opleiden van ZHA-en een succes wordt?
5. Hebben de verschillende betrokkenen de taken uitgevoerd zoals afgesproken?
6. Worden doelen bereikt (zoals aantal ZHA, opleidingsdoelen, etc.)? Zo niet, wat is de reden dat doelen niet worden bereikt?
7. Op welke manier wordt de begeleiding van ZHA vormgegeven? Wat gaat hierin goed, wat kan beter?
8. Hoe verloopt de samenwerking tussen alle betrokken partijen?

De volgende vragen gaan over de verwachtingen van de stakeholders tbv de implementatie.

9. Welke positieve omstandigheden en randvoorwaarden ziet u voor het implementeren van de ZHA? Zijn er kansen waarop ingespeeld kan worden?
10. Wat zijn potentiele barrières bij het uitvoeren van het implementatieproject?
11. Op welke manier kan op deze potentiele barrières worden geanticipeerd?
12. Wie kan er voor zorgen dat het implementeren van de ZHA een succes wordt?

Afsluitend

Zijn er nog onderwerpen niet aan de orde gekomen die wel van belang zijn voor het monitoren en beoordelen van de voortgang van het implementatieproces? Of zaken die u om een andere reden graag kwijt wilt?

Hartelijk dank voor het geven van uw visie en voor alle informatie. We sturen u op korte termijn een verslag van dit gesprek. U kunt dit verslag controleren op juistheid en eventuele aanvullende informatie geven. We gaan met alle informatie vertrouwelijk om in de zin dat de terugrapportage zo min mogelijk tot individuele personen herleidbaar zijn.

Appendix II: Stakeholder Identification (TGO and RUG)[4]

STAKEHOLDERSIDENTIFICATIE

Abe Meininger, Marjolein van Offenbeek en Annemieke Visser

Een stakeholder is een persoon die of actief bij een project is betrokken of wiens belangen door het uitvoeren van een project of door het projectresultaat kunnen worden beïnvloed.

Bij het identificeren van stakeholders wordt aansluiting gezocht bij Achterkamp en Vos (2007). Zij maken gebruik van een methode die bestaat uit vier stappen, waarin aan de hand van een brainstorm de stakeholders worden geïdentificeerd.

1. Definiëren van het doel van het project
2. Individuele brainstorm waarin deelnemers ieder afzonderlijk wordt gevraagd alle partijen (mensen, groepen mensen of organisaties) die mogelijke betrokkenheid hebben bij het uitvoeren van het project op te schrijven
3. Groepsbrainstorm waarin deelnemers wordt gevraagd alle partijen te noemen die vanuit verschillende rollen (afnemer, besluitvormer, ontwerper/expert, passief betrokken) het project kunnen beïnvloeden
4. Groepsbrainstorm waarin deelnemers wordt gevraagd die stakeholders te selecteren die het proces gericht op het opleiden en inzetten van de Ziekenhuisarts (ZHA) kunnen beïnvloeden

Ad. 1 Definiëren en verdere afbakening van het doel

De doelstelling van de Stichting Opleiding Ziekenhuisgeneeskunde is te komen tot een verbeterde kwaliteit van zorg, (kosten)efficiënte zorg, verbeterde organisatie van zorg en een gedifferentieerd carrièreperspectief van de jonge arts.

Voor het slagen van het project wordt in het bijzonder aandacht besteed aan de volgende kritische issues:

1. Wordt de ZHA in opleiding (io) op de werkplek gefaciliteerd (leersituaties) en gecoacht in het ontwikkelen van de specifiek beoogde competenties (zie functie/opleidingsprofiel, d.w.z.

[4] Names of Stakeholders have been deleted for anonymity purposes.

benodigd voor bijdragen aan patiëntveiligheid, continuïteit en keten en samenwerking)? NB. Dit houdt in feite het experimenteren met (mogelijke onderdelen van) de nieuwe functie in.

2. Convergeren de feitelijke opleidingsplannen binnen de lokale ziekenhuispraktijk met het formele opleidingsplan?

Ad. 2/3 Identificeren van stakeholders en de rol die zij innemen

Tijdens stap 2 zijn 27 stakeholders geïdentificeerd die allen kunnen worden ondergebracht bij een of meer van de onderstaande stakeholdersrollen.

Rol 1: Afnemer

Een afnemer is degene die de diensten of producten van het project gebruikt of afneemt. Het project ontleent hieraan haar doel.

De partijen die als *afnemers* worden beschouwd zijn:

- Patiënten
- Zorgverzekeraars
- Medisch hoofden van de stage afdelingen, dit zijn de afdelingen Interne geneeskunde, Heelkunde, Neurologie en Anesthesiologie, Verpleeghuis of een huisartsenpraktijk.
- Medisch hoofden van (onder-)afdelingen, als geriatrie
- Specialisten ouderengeneeskunde (verpleeghuis)
- Huisartsen/1^{e} lijn
- Andere werkplekken, bijvoorbeeld verpleeghuis

Rol 2: Besluitvormer

De besluitvormer stelt eisen of randvoorwaarden waaraan het veranderings- of innovatieproject moet voldoen en/of evalueert of het project hieraan voldoet.

De partijen die als besluitvormer moeten worden beschouwd:

- Raden van Bestuur, mede vertegenwoordigd in bestuur SOZG
- VWS
- Medisch hoofden van ziekenhuisafdelingen, mede vertegenwoordigd in bestuur SOZG
- Aanspreekpunt/ voorzitter centrale opleidingscommissie
- Beroepsverenigingen van medisch specialismen NFU, als partij namens UMC's
- STZ, namens Top(opleidings)ziekenhuizen
- CGS (college geneeskundige specialismen)

Rol 3: Ontwerper/Expert

Deontwerper/expert is verantwoordelijk voor het opleveren van (tussen)producten in het veranderings- of innovatieproject of draagt actief specifieke kennis en/of vaardigheden bij.

De partijen die als *ontwerper/expert(s) moeten* worden beschouwd zijn:

- Betrokken opleidingsadviseurs en onderwijskundigen
- ZHA-en io

- Opleiders ZHA
- Plaatsvervangend opleiders ZHA
- Stagebegeleiders ZHA van de afdelingen
- Kwaliteitsfunctionarissen
- Liaison officer binnen het concilium (of SOZG)

Rol 4: Passief betrokkenen of representanten hiervan

Een passief betrokkene ondervindt gevolgen (negatief of positief) van de activiteiten van het veranderings- of innovatieproject zonder zelf direct de mogelijkheid te hebben het project te beïnvloeden. Dit zijn veelal actoren met wie wordt samengewerkt binnen het ziekenhuis of de keten.

De partijen/personen die de passief betrokkenen representeren zijn:

- Opleiders moederspecialismen (op stage afdelingen, bv effecten op hun aios)
- ANIOS (effecten op hun werkgelegenheid)
- Arts assistenten i.o. (effecten op hun taken en werkbelasting en samenwerking)
- Physician assistenten (effecten op hun taken en werkbelasting en samenwerking)
- Verpleegkundig specialisten (effecten op hun taken en werkbelasting en samenwerking)
- 1^{e} lijn, huisartsen (effecten op transmurale samenwerking)
- Patiënten (effecten op kwaliteit en continuïteit, en samenwerking in de keten)

Ad. 4 Selecteren van deelnemers

Bij het selecteren van stakeholders is gekozen voor het betrekken van die mensen die invloed hebben, dus het selecteren van de 'keep satisfied' en de 'try to collaborate' (zie matrix Figuur 1). Er wordt onderscheid gemaakt in primaire en secundaire stakeholders. De primaire stakeholders hebben grote invloed en direct belang bij het slagen van het project en vervullen een van de eerste drie van bovenstaande rollen (afnemer, besluitvormer of ontwerper/expert). De secundaire stakeholders hebben geen direct belang, maar wel invloed. Zij vervullen vaak de vierde rol (passief betrokkenen). Aangezien er binnen dit project ruimte is voor 48 interviews (waarbinnen primaire stakeholders twee keer worden geïnterviewd) selecteren we die stakeholders die het meeste invloed hebben c.q. het meeste "geraakt" worden.

Op basis van de stakeholdersidentificatie is gekomen tot de volgende *primaire stakeholders* die op twee momenten geïnterviewd gaan worden:

1. Twee ZHA i.o. per ziekenhuis (n =8)
    a. UMCG (?,?)
    b. VUMC (?,?)
    c. Jeroen Bosch (?,?)
    d. Catharina ziekenhuis (?,?)
2. RvB van twee ziekenhuizen (n=2)
    a. VUMC,

   b. Jeroen Bosch,
3. Medische hoofden Interne geneeskunde van twee ziekenhuizen (n=2)
   a. UMCG
   b. Catharina ziekenhuis
4. Een opleider en een plaatsvervangend opleider (n=2),
   a. Opleider VUMC
   b. Plaatsvervangend opleider Jeroen Bosch,
5. Stagebegeleiders (per ziekenhuis een specialisme) (n=4)
   a. UMCG
   b. VUMC
   c. Jeroen Bosch
   d. Catharina ziekenhuis
6. Liaison officer concilium,

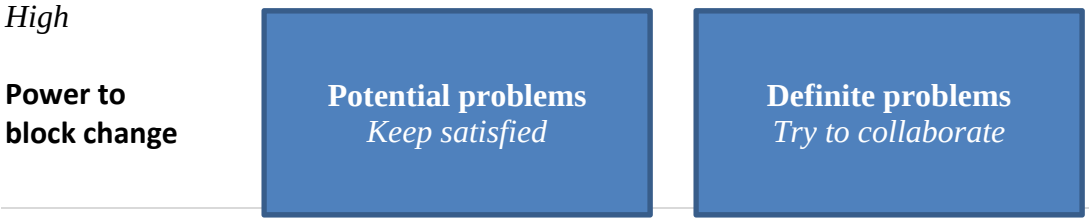
Onderstaand volgt de selectie van de *secundaire stakeholder.* Zij worden op een moment geïnterviewd.

1. Vertegenwoordiger van vpk (n= 1)
2. Vertegenwoordiger college Geneeskundige Specialismen (CGS) (n=1)
3. Lokale vereniging van arts-assistenten van een ziekenhuis (n=1) UMCG
4. Opleider moedersspecialismen (n=1
5. Huisartsen (huisarts die overkoepelende organisatie kan vertegenwoordigen) (n=2)
6. Physician assistents van stageafdelingen (n= 2)
7. Verpleegkundig specialisten in twee ziekenhuizen (n =2)

Overige afspraken:

1. De uitkomsten van de stakeholdersidentificatie worden aan xx voorgelegd en hem wordt gevraagd of hij nog aanvullingen heeft c.q. betrokkenheid wil
2. De resultaten van de stakeholdersidentificatie wordt aan xx en aan xx voorgelegd en zij worden uitgenodigd deze identificatie eventueel aan te vullen. Dit hoeft geen consequenties te hebben voor de selectie van welke SH'ers te interviewen.
3. De mening van beroepsverenigingen over het inzetten van de ziekenhuisarts proberen te achterhalen (dmv documenten of vertegenwoordigers van deze groep die aan interview deelnemen hiernaar vragen)

Figuur 1: Powermatrix



Appendix IIIa

Summary of Results

	Cognitive-Technical Rationality	# of times mentioned by stakeholders	Professional Identity Rationality	# of times mentioned by stakeholders
Driving Forces	The need for more coordination and continuity is highly recognized, which the Hospitalist would realize.	HiE: 6/6 MS: 3/3 HM: 3/3 CGS: 1/1 EDU: 2/2 PA: 1/1 NP: 1/1 Total: 17/17	Specialists are much more likely to delegate to other doctors (Hospitalists), instead of nursing professions.	HiE: 3/6 MS: 2/3 HM: 1/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 0/1 Total: 9/17
	External trends of complex patients suffering from multiple illnesses is recognized by stakeholders, Hospitalist would be able to address this patient stream.	HiE: 5/6 MS: 3/3 HM: 3/3 CGS: 1/1 EDU: 2/2 PA: 0/1 NP: 1/1 Total: 15/17	Nursing professions like having a doctor on the ward who is 'one of them', dealing with the same issues, and concerned with their work.	HiE: 4/6 MS: 2/3 HM: 1/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 9/17

	Especially in small hospitals where there are not many residents, having a general doctor who can do some of the specialist's tasks will lead to more flexibility.	HiE: 4/6 MS: 2/3 HM: 2/3 CGS: 1/1 EDU: 2/2 PA: 1/1 NP: 1/1 Total: 13/17	Doctors did not just become specialists for the money, but to help people. If they realize that delegating is best for the patient, they will.	HiE: 2/6 MS: 2/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 8/17
	Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.	HiE: 3/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 1/1 Total: 12/17	The hospitalist could ensure the interface between two paradigms in a hospital: 'We will cure you' and 'we will make your life as pleasant as possible'	HiE: 0/6 MS: 0/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 0/1 Total: 5/17
	Asking specialists in consultation for every issue is expensive, so Hospitalists reduce costs, since less specialist consultations are necessary.	HiE: 5/6 MS: 2/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 0/1 Total: 12/17	Doctors have limited time, the Hospitalist enables specialists to do what their good at, and educated for. The specialist's job will be more attractive as well.	HiE: 3/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 1/1 Total: 12/17
	Most of the times, PA's, NP's and other Specialized Nurses have to ask a specialist to approve medical decisions (diagnoses, medication), which slows the entire process down. A Hospitalist would be authorized to make these decisions, and would be closer to the nursing professions, speeding up the process.	HiE: 4/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 11/17		
	PA's, NP's and other Specialized Nurses have sometimes taken on certain tasks now, which they are not qualified for. A Hospitalist would be qualified for this work.	HiE: 4/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 11/17		

	The unclear boundaries (positioning) for the Hospitalist makes the profession flexible at implementation: the job can entail tasks and part of domains based on local needs.	HiE: 2/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 9/17	
	The tasks on the ward are now also done by residents, who are either not experienced enough, or lack the knowledge necessary.	HiE: 5/6 MS: 1/3 HM: 1/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 9/17	
	Because of the overlapping domains, and the central position of the Hospitalist in this, they can take a leading role in designing better multi-disciplinary, well-coordinated treatment plans for patients.	HiE: 3/6 MS: 1/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 1/1 Total: 9/17	
	The experience of creating a similar medical profession, the EP, can be used to guide this process. It is also argued that hospitals 'have learned from their mistakes'. HM argued that these mistakes included an initial group of EP that was too large to handle.	HiE: 2/6 MS: 2/3 HM: 3/3 CGS: 1/1 EDU: 2/2 PA: 0/1 NP: 0/1 Total: 9/17	

Figure 11a: Driving Forces

Appendix IIIb

Summary of Results

	Cognitive-Technical Rationality	# of times mentioned by stakeholders	Professional Identity Rationality	# of times mentioned by stakeholders
Restraining Forces	It is still unclear who is going to pay for the initial costs of introducing the Hospitalist.	HiE: 4/6 MS: 2/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 1/1 Total: 12/17	In peripheral hospitals, some specialists might feel that the Hospitalist takes away part of their job, and thus reduces their house's income.	HiE: 4/6 MS: 3/3 HM: 3/3 CGS: 1/1 EDU: 1/2 PA: 1/1 NP: 0/1 Total: 13/17
	If Hospitalists are doing all the work on a ward, there might not be enough vacancies for residents to learn this part of the job.	HiE: 3/6 MS: 3/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 10/17	Specialists naturally feel responsible for their patients, it is doubtful whether they will hand this over to somebody else.	HiE: 4/6 MS: 3/3 HM: 2/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 11/17
	The overlap in the knowledge Hospitalists should have with different specialties makes it difficult to choose what they should be educated in specifically.	HiE: 2/6 MS: 2/3 HM: 1/3 CGS: 1/1 EDU: 2/2 PA: 0/1 NP: 0/1 Total: 8/17	Some tasks in the Hospitalist's job description are being done by PA's, NP's and other Specialized Nurses, they might protect that domain. Especially when the Hospitalist's domain boundaries (positioning) are unclear.	HiE: 4/6 MS: 1/3 HM: 2/3 CGS: 0/1 EDU: 1/2 PA: 1/1 NP: 1/1 Total: 10/17

	Taking the opportunities away for doctors to select promising residents based on their work on a ward.	HiE: 0/6 MS: 3/3 HM: 2/3 CGS: 1/1 EDU: 2/2 PA: 0/1 NP: 0/1 Total: 7/17	If the Hospitalist is seen as of lower 'status' than a specialist, it is doubtful whether the specialists will delegate responsibilities.	HiE: 3/6 MS: 1/3 HM: 1/3 CGS: 1/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 7/17
	Underestimating of the importance of clear positioning of the Hospitalist. It can be argued that postioning is necessary (see Discussion).	HiE: 2/6 MS: 1/3 HM: 2/3 CGS: 0/1 EDU: 1/2 PA: 0/1 NP: 0/1 Total: 6/17	Difficulty of breaking through the paradigm of 'curing people' towards providing them with a higher quality of life.	HiE: 0/6 MS: 1/3 HM: 1/3 CGS: 1/1 EDU: 0/2 PA: 0/1 NP: 0/1 Total: 3/17